

47 (1977)

JANUARY

# children

AN INTERDISCIPLINARY JOURNAL FOR THE STUDY OF CHILDREN





# children<sup>®</sup>

VOLUME 5

NUMBER 1

JANUARY-FEBRUARY 1958

H V  
741  
A362

School and Community Human-Relations Programs . . . . .	3
<i>Joseph H. Douglass</i>	
Changing Emphases in School Health Programs . . . . .	9
<i>Arthur J. Lesser</i>	
Helping Parents of Handicapped Children . .	15
<i>Eleanor S. Reid</i>	
Coordinating Health Services for Handicapped Children . . . . .	20
<i>Helen M. Wallace</i>	
The Role of Informal Inmate Groups in Change of Values . . . . .	25
<i>George H. Grosser</i>	
Change Is The Way of Life . . . . .	30
<i>Muriel W. Brown</i>	
Book Notes . . . . .	34
Here and There . . . . .	35
In the Journals . . . . .	39
Readers' Exchange . . . . .	40

◀  
 A Puerto Rican child in New York, a member of one of the many thousands of families who have poured into the city from the Caribbean island since the end of World War II, bringing with them language and

cultural differences which have created many problems for them in the community. How to preserve good human relations within communities as the ethnic composition changes is suggested by the article on page 3.

Sociologist Joseph H. Douglass came to the Department of Health, Education, and Welfare in 1954 as consultant on intergroup education in the Office of Education and later became special assistant to the Secretary. A graduate of Fisk and Harvard Universities, he has been dean of the Fayetteville (N. C.) State Teachers College, on the faculty of Howard University, and executive secretary of the Washington Urban League.



Before assuming his present position 6 years ago Arthur Lesser was for 3 years chief of program planning for the Children's Bureau's division of health services and for 8 years medical director for Region III. With a medical degree from Washington University in St. Louis, he trained in pediatrics at Children's Memorial and Municipal Contagious Diseases Hospitals in Chicago and at Mt. Sinai Hospital in New York.



Eleanor Reid's article grew out of her experience at the hospital school where she had been on loan from the Iowa Crippled Children's Services to develop social services. With training from the schools of social work at Columbia University and the State University of Iowa, Mrs. Reid has also worked in foster care programs in New York City and with the American Friends Service Committee in Palestine. She now lives in Pennsylvania.



Dr. Helen Wallace has written widely about research undertaken by New York City's Department of Health when she was director of its crippled children's program. She was with that department for 12 years before turning to public health education, first as director of the department of public health at the New York Medical College and, since the fall of 1956, at the University of Minnesota.



With an interest in developing treatment methods for juvenile delinquents out of sociopsychological research George Grosser has achieved a doctorate at Harvard University and served successively as diagnostician and counselor at the Boston Juvenile Court and the Lyman School and as director of the clinical staff at Youth Service Board Detention Center in Boston. He has been at Queens College since 1953.



Psychologist Muriel Brown came to the Children's Bureau a year ago after 10 years of working on overseas assignments for the Army, the Department of State and the Josiah Macy, Jr., and Ford Foundations. A research specialist in parent and family life education, she has been with the National Council of Parent Education, the University of Tulsa and the U. S. Office of Education.



## ◀ the authors

### National Advisers to CHILDREN:

Walter A. Adams, M. D.  
John S. Bradway, LL. B.  
Ruth Gilbert, R. N., M. A.  
Reginald S. Lourie, M. D.  
Boyd McCandless, Ph. D.  
Margaret B. McFarland, Ph. D.  
Lucy Morgan, Ph. D.  
John L. Parks, M. D.  
Helen H. Perlman, M. S.  
Helen Ross  
Edward R. Schlesinger, M. D.  
Myrtle P. Wolff, A. M.

### Editorial Advisory Board:

Elizabeth Herzog, *Chairman*  
*Social Science*

Mildred Arnold  
*Social Work*

Katherine Bain, M. D.  
*Pediatrics*

Lincoln Daniels, M. A.  
*Community Organization*

Virginia Insley, M. S. W.  
*Medical Social Work*

### Editor:

Kathryn Close

*Changes in community make-up and school policies are behind the need for . . .*

# SCHOOL AND COMMUNITY HUMAN-RELATIONS PROGRAMS

JOSEPH H. DOUGLASS, Ph. D.

*Program Coordination Officer, Office of the Secretary, Department of Health, Education, and Welfare*

**T**HE PURPOSE of this analysis is twofold: (1) To identify some of the problems and tensions which arise in communities and school systems as they develop human relations programs, and (2) to suggest some possible methods and approaches by which school administrators, teachers and the public might cope with them. The goal of a human-relations program, as perceived by Boykin, is a "unity of interacting personalities bound together in an organized relationship in which the characteristic mode of social interaction is determined not by racial or ethnic differences, interfaith conflicts, socio-economic disparities and cultural and educational factors, but by respect for individual personality, and the dignity and worth of human beings."<sup>1</sup>

Among the problems which may confront schools and communities in the development of human-relations programs are those arising from:

1. Population growth, change, and mobility;
2. An expanded conception of the role of the school as a community agency;
3. Attitude of ethnic groups growing out of previous majority-minority relationships;
4. Inexperience of staff in planning and implementing a school human-relations program;
5. Lag in community education toward the program;

6. Administration anxieties with reference to the success of the school program under way;
7. Internal and external "pressures" affecting the school-community equilibrium.

## *Community Changes*

Numerous communities and schools recently have undergone an unprecedented population increase as a result of the postwar boom in births. By 1955 the elementary-school population numbered 30.5 million, or an increase of 37 percent above the 1940 total. A continuous increase in school population is likely to confront communities for some time to come.

At the same time the population has surged to the cities. Between 1900 and 1950 the metropolitan areas absorbed 73 percent of the Nation's total growth. As a result, the schools, as Hauser says, have been faced more and more with the necessity of "adaptation of the instructional program to general and specific preparation for urbanism as a way of life."<sup>2</sup>

Recently great changes have taken place in the ethnic and racial makeup of metropolitan communities. The majority of newer city arrivals have not been foreign immigrants as they used to be, but Negroes of low economic status who have moved in from rural communities. By 1950, over 90 percent of the Negroes in the North and West, and 48 per-

cent of those remaining in the South lived in urban areas. In urban communities into which large numbers of Negroes have migrated, the schools have been only one of the agencies faced with problems of accommodation.

These trends in population shifts can be expected to continue. As a consequence, in addition to problems of adequate facilities and staffing, schools and communities are faced with adjustments to problems created by changes in ratios and concentrations of ethnic groups in the population. In many schools where the child population until recently has been predominantly white, the situation is being reversed. This puts a responsibility on the school administration to consider, as Hauser suggests, "whether the instructional program conveys an insightful description and understanding of the human-relations problems which are involved, and adequately prepares students for dealing with them with a minimum of friction and hardships?"<sup>2</sup>

While these shifts in population have been occurring the Nation has also been undergoing other social changes including increases in the average size of family, the proportion of aged in the population, and proportion of women in the labor force. Each of these developments is creating complex human-relations problems which either directly or indirectly affect the role and function of the school.

### *Expanded School Roles*

More and more the schools are expanding their roles to help cope with the varying needs of all the people of all ages in the community. They are, for instance, providing opportunities for continuing educational experiences for adults that will be helpful to them in maintaining health, planning for parenthood, child-rearing, acquiring or improving job skills, and carrying out civic responsibilities. Similarly, schools are beginning to accept a responsibility for safety education, driver training, premarital counseling and other types of adult education protective not only of the individual but of society as a whole. Growing numbers of groups and individuals with special needs are turning to the schools for specialized assistance while the schools are turning to the specialized agencies and specialists in the community for assistance in their educational programs.

In many communities into which Negroes are moving from rural areas, large numbers of white residents are moving outward to suburban fringes. The newer residential suburbs are characterized by a

high degree of similarity among the residents, in income levels, social interests, and ethnic identification.

By design or otherwise, Negroes and some other minorities are, with few exceptions, excluded from these new suburbs.

Thus many Negroes are finding residences in city areas which have been vacated by whites. To a large extent these areas surround or are interspersed with older business and commercial sections and are typically "low-income status" in comparison with white residential areas. One main cause of segregation of children in school along ethnic and economic lines is this factor of physical residential separation of the populace on the bases of ethnic identity and high and low status lines. New York City currently is wrestling with this problem by transporting students to schools in neighborhoods other than where they reside.

### *Lack of Communication*

Another major problem growing out of residential separation is its effect in maintaining closed channels of intergroup communication and participation. This tends to encourage psychological isolation, attitudinal withdrawal, ethnocentrism, stereotyping, the development of rumor, and actual or potential intergroup hostility or tension.

The vicious circle of residential separation, lack of communication, lack of interparticipation, and the ascription of lower-class status to minority groups tends not only to enhance group loyalties on the basis of ethnic identity, but also to concentrate the control over community affairs in the majority group. This tends to entrench a caste-like situation, especially in respect to Negroes and whites. From the standpoint of occupations, income levels, prestige, leadership, and authority, many members of the white group are at, or above, the norms which both groups look upon as desirable, and members of the Negro group are largely below.

The result of such separateness is that the minority groups tend not only to be categorically looked down upon by the majority group, but to look down upon themselves as persons and as groups. The facts of being regarded inferior on the one hand and of so regarding themselves on the other, heighten their feelings of insecurity, inferiority, and apathy. At the same time, such attitudes tend to incite their feelings of hostility and resentment toward the majority group, thus stimulating aggressive behavior. The more aggressive the minority group, the more

negative is the reaction of the majority group, thus still further crystallizing the ethnic isolation of each group.

### *Attitudinal Problems*

Consider now the school system in which an effort is being made to develop a human-relations program, in compliance with a Supreme Court decision with which a sizable proportion of the community is out of sympathy.

In many areas, as previously pointed out, schools already are grappling with problems of overcrowding, staff shortages, insufficient materials, low salaries and inadequate facilities. A large number of "small" school buildings are located in neighborhoods which are undergoing a transition in the racial identity of the inhabitants. Groups and individuals which previously had been separated and isolated largely on the basis of unequal opportunities are now to be brought together theoretically on an equal basis. In both groups anxieties and fears immediately arise among parents, pupils, administrators, and teachers as a result of the lack of previous contact and experience. These are conditioned by the relationships and attitudes which the groups and individuals have habitually had toward each other.

Seldom is there complete sympathy on the part of all publics in a community for the idea of integration as a school policy. Many persons in the majority group fear that bringing children of diverse groups together will lower the ethical and moral standards of their children and the academic standards of the entire school because of the inferior cultural and educational opportunities in the minority group's background. Some are concerned about the possibility of miscegenation. Other fears grow out of the majority's stereotyped thinking about the minority with reference to disease and standards of cleanliness. There are also fears of physical violence and personal bodily harm growing out of group hostility. These fears, anxieties, and tensions frequently produce a high degree of resentment on both sides.

In the minority groups, the movement toward integration is also approached with fears and misgivings. The major anxieties arise from the prospect of nonacceptance or psychological rejection. Members of the minority group are afraid of being laughed at or "made fun of" by persons who in their previous group isolation were conditioned to feelings of superiority. They fear that if a con-

flict should arise, they will be judged *ipso facto* as being at fault. Often, the minority students expect less than fair and equal treatment from their teacher.

Sometimes, all these fears are reversed, and the minority person is afraid of being overaccepted to the point of being regarded as something special, in which case he would still feel uncomfortable. Having labored so long under a feeling of inferiority, the student in a minority group is sometimes afraid that he will be unable to keep up scholastically with the students of the majority group, even under optimal conditions. He feels that he must be constantly on his guard to protect himself or to defend his conception of his personal honor or self-esteem. However, if, by chance, he is successful in being accepted as an individual by the students of the majority group, he sometimes suffers a guilty feeling of having been disloyal to his own group.

A successful attack on these problems requires the utmost skill, human understanding and individual dedication on the part of administrators and teachers in replacing feelings of insecurity with those of security and feelings of inadequacy with those of adequacy.

### *Staff Inexperience*

A major difficulty in getting effective human-relations programs under way often lies in the inexperience of instructional and administrative staff in coping with the interpersonal and intergroup problems arising in a heterogeneous school population.

Because of policy or location there are three types of schools today: (1) those undergoing a transition from racial segregation to integration; (2) those in which integration has long been established; (3) and those in which segregation of the races is a continuing fact.

Each of these situations presents its peculiar problems. In the schools and communities where integration has been long established, the adjustments to increasing numbers of minority persons are probably not as difficult as in the schools effecting a new integration policy. In the transitional situation apprehensions, misgivings, anxieties, and fear may be acute unless the process of arriving at the policy decision involved widespread community participation and support. If this has been the case, school and community may work together positively, anticipating success. If this has not been the case, the community may be so divided in attitude that the school finds itself in the middle of opposing forces.

Where segregation of the races is a continuing fact backed up solidly by community attitudes any change will depend on the kind of leadership that is exerted in the interest of human-relations programs.

In the transitional and segregated schools many of the teachers themselves may have unfavorable preconceived notions concerning minority groups. Without previous experience and contact with varied ethnic groups, they may lack understanding of what "others" are like, how they feel or what motivations and values are present. When teachers do not know what the children's lives are like, there is a great danger of their misinterpreting the children's behavior, and, as a consequence, of doing or saying things which create misunderstandings and thus intensify rather than reduce problems.<sup>3</sup>

### *The Pressures*

On the administrator depends to a large extent the degree of morale, the organizational efficiency, and other aspects of the success of the school's program. He is the target for criticism from all sides, yet teachers, pupils, parents, the board of education, and the community at large look to him for leadership and direction. He often finds himself in the middle of cross-pressure of conflicting interests among these groups. And because he is human, he also often has in him a mixture of motives, rational and irrational, self-interested and group-interested, conscious and unconscious. These psychosocial pressures may cause problems in his successful adjustment to and direction of the school's program.

Among causes for fear and anxiety, the administrator faces the possibility of loss of status with the groups and individuals who are important to him. He needs great conviction when he has to stand for principles to which the community is largely indifferent or even directly opposed. He may even find that his role places him in an antithetical position to the community power structure, presenting the danger of a break between himself and those to whom he is officially responsible.

The administrator may also fear the future consequences of a particular course of action, such as the wholesale withdrawal by parents of their children from the school because of the decision to hire Negro teachers.<sup>4</sup> However, his problems may be lessened in new channels of community participation and communication are opened up by bringing together representatives of all groups for mutual planning and accomplishment of community goals, including the special talents of those groups not di-

rectly involved with school problems, such as representatives of civic organizations, church groups, and health and welfare agencies.

In addition to influences and pressures from the outside, a school organization contains various internal pressures. These are brought to bear on the children, the teachers, and the administrator. The members of each group are subject to a complex of stated and implied expectations which apply between and among these groups. The teachers face problems of personal capabilities, of performance and rewards, of getting on with their colleagues, of maintaining the esteem of the administrators, and of fulfilling responsibilities for instructing the children. The administrator faces problems of policy execution, of delegation of authority, of organization, of leadership and coordination. The children face problems of living up to the teachers' and administrators' goals, responding to group relationships among their peers, and fulfilling parental expectations in a competitive situation.

Externally, the community exerts pressure on the school organization in terms of parental and civic expectations. Parents view the teachers as the professional guides for their children. The community expects the children to be safe, happy, and busily engaged in purposeful activity while absorbing useful knowledge and information.

Apparently an equilibrium grows out of the many forces at work whereby the many needs, motives, objectives, and desires are in some degree realized.

Traditionally, the many expectations of the school have grown out of the values and goals of average white American middle-class children, parents, and teachers. For these, the programs, policies, purposes, and organization have been designed. The minority child, parent, or teacher constitutes a threat to the existing equilibrium. The greater the deviation from the norm presented in language, religion, color, social status, or other attribute, the greater are the problems of adaptation in school-community relationships.

The problem of interpreting the school's program to the community is crucial. Success depends on working through and with existing community organizations, of setting short-range and long-range goals and of involving numerous groups and individuals into an action or an educational program. The parent-teachers association can help bridge the gap between school and community by facilitating the cooperation of parents, teachers and administrators. According to Caldwell and Foster, "grow-

ing communities tend to act more rapidly than static or declining communities. Urban communities tend to respond to new appeals more rapidly than rural, and new communities more quickly than old."<sup>5</sup>

The school that is most successful in interpreting its program is the one which involves the community most effectively in programs of joint participation of school and community groups.

### *Coping With Problems*

In coping with the problems of schools and communities through a human-relations program, the best of what we already know concerning democratic practices must be applied along with some new approaches for bringing about adjustment to the changing social and psychological circumstances of our times.

Changes in family relationships, increased population mobility, man's venture into space and new sources of energy, technological developments, and changes in international relations are among the forces underscoring the need for rethinking our basic concepts and heightening the adaptability of our institutions and agencies.

Along with their historic responsibility for transmitting the cultural heritage and inculcating fundamental knowledge in young people, schools are finding it necessary to orient their programs to: (1) a concept of their expanding service role in the community; (2) a perception of the total community as the unit for planning and action; and (3) a belief in a respect for individual personality as the best means of maintaining and realizing the ideals of the democratic life. In such schools the philosophy of education moves toward a perception of the total relatedness and interdependence of all groups and individuals of the community: Some educators are also beginning to recognize that since we cannot rid our society of all tensions, part of our educational efforts must be directed toward helping young people to learn how to cope with tensions.

Surrounding the school are institutions and agencies such as the family, the church, the banks, the communication agencies, welfare agencies, labor unions, and service institutions. Through its administrators, teachers, and pupils, the human-relations-conscious school relates its programs and activities to the services and programs in which these agencies are involved and assists in the development of channels by which the great body of community agencies can help the school to broaden its programs. Such an approach ideally makes it possible for all individ-

uals and groups in the community to gain from the school those specialized services which the school can render them and to bring to the schools services and resources to enrich the school program.

This approach entails knowledge of the community's resources and needs, as well as participation of all community agencies and interest groups in overall community planning for meeting human needs. It excludes narrow consideration of race, creed, or economic position as determinants for participation.

Thus, with the help of the community agencies, the school seeks to develop a community plan whereby the people themselves, on a cooperative basis, undertake to meet their many needs. Schools are not then divorced from the community and the community is not separated from them. Conflicts are at a minimum because those who interpret specialized needs are referring to needs they know at first hand and have the trust of others since they are helping to meet all needs of the community.

This is in harmony with the basic principles of our democratic society. However, experience has shown that in many areas we have not sought to bring about the necessary framework for accomplishing this. On the other hand, research findings on group behavior are being applied to smooth the way for good human relations in numerous practical situations—in school programs, in overall community planning, in planning for housing projects, in police training institutes, in recreation programs, and in the provision of social services. Although many studies of group dynamics present inconclusive and diverse findings, as knowledge is gained in this field reliable techniques for lessening group tensions may be devised.

Much has been achieved in defining the nature of the social and psychological problems in today's society. For example, studies have revealed the detrimental effects of group and individual prejudices on those who hold them as well as on those against whom they are held. The so-called "roots" of prejudice have been determined, and the genesis of prejudicial attitudes in children has been repeatedly observed. Research has demonstrated that prejudice can be reduced and unlearned under a wide range of circumstances.

It has been found that mere contact between groups is insufficient as a technique for reducing prejudice. Much more depends upon the kinds of contacts which the groups have. It is known that under certain conditions, role playing, sociodrama,

and so-called "group-retraining" devices can reduce hostility among groups. It can also be reduced in individuals. We know too that the media of mass communication might be used successfully in the reduction of prejudice in individuals who are not deeply committed in their attitudes. It has also been discovered that a high positive correlation does not always exist between prejudice in the individual and discriminatory actions—although prejudiced, the individual, in some social situations, might not attempt to discriminate.

### *Possible Approaches*

A number of constructive methods are available to school administrators for developing good human relations in the school community:

1. Fostering and supporting common purpose situations which can involve cooperation across groups and organization lines.
2. Encouraging students, parents, and teachers to regard the school and community as laboratories in which they can work together to learn about diverse cultural groups.
3. Involving parents and citizens in appropriate school activities.
4. Promoting in-service programs and workshops for teachers and administrators in cooperation with human-relations organizations.
5. Disseminating to the community facts which show the contribution of all groups to the enrichment of American life and to the maintenance of the Nation's vitality.
6. Adding to the school curriculum information about the major contributions of all ethnic groups to the development of our society.
7. Involving students, teachers, administrators and the board of education in periodic all-school evaluations of school practices, use of facilities, and student participation in activities.
8. Encouraging community groups to use the school program and facilities in their efforts to accomplish their purposes.
9. Within the school, placing responsibility for setting and enforcing standards of group behavior on the student group.

These approaches are predicted on the assumption that through the provision of opportunity for living in an environment which demonstrates desirable practices and encourages relinquishment of prejudices and the acceptance of other human beings on the basis of individual merit, prejudicial attitudes may be altered and tensions reduced. The approaches are also based on "belief in a basic fact that each one of us, in order to live his life fully, must feel the sense of personal worth which can come only from being accepted as an equal by those whom we meet in our daily lives."<sup>6</sup>

They are also based on the assumption that we have reached the point in our social progress where most human ills can be prevented. The objective of democracy—to permit each individual to develop to his maximum capabilities—cannot be accomplished by encouraging the individual to become isolated from his fellows or forcing him to live in an environment in which he feels that he does not belong. It can only be achieved if the individual, irrespective of who he is, will have opportunity and responsibility as a member of the community to participate in making the community a better place in which to live for everyone, including himself.

There are hundreds of communities over the land where human-relations problems are at a minimum, where persons of variant ethnic groups live in harmony. To attain this kind of environment in all of our communities means the establishment in each community of an all-inclusive community approach so that every individual knows that he belongs and in so belonging has an obligation to be of service to his fellow man.

<sup>1</sup> Boykins, Leander L.: Let's get it straight: What are human relations? *Social Studies*, February 1955.

<sup>2</sup> Hauser, Philip M.: Population facts and factors. *The National Elementary Principal*, February 1957.

<sup>3</sup> Hardiman, Ruth N. (editor): Human relations in action: pupils, parents, and teachers work together. A report of the study for inter-group education in the elementary schools. Denver: Denver Public Schools, 1952.

<sup>4</sup> Griffiths, Daniel E.: Human relations in school administration. New York: Appleton-Century-Crofts, Inc., 1956. (p. 5.)

<sup>5</sup> Caldwell, Morris G.; Foster, Laurence: Analysis of social problems. Harrisburg, Pa.: The Stackpole Co., 1954. (p. 533.)

<sup>6</sup> Taylor, Harold: The ideals of American youth. In *Human relations in higher education*. Washington, D. C.: American Council on Education, September 1951. (p. 28.)

*Changes in the major health problems  
besetting children call for . . .*

# CHANGING EMPHASES IN SCHOOL HEALTH PROGRAMS

ARTHUR J. LESSER, M. D.

*Director, Division of Health Services, Children's Bureau*

THE PARTNERSHIP of education and medicine that is essential for a school health program has been expressed in many ways but hardly more simply and directly than in a report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.<sup>1</sup> The report lists these functions of a school health program:

1. To appraise the health status of pupils and school personnel.
2. To counsel pupils, parents, and others concerning appraisal findings.
3. To encourage the correction of remediable defects.
4. To assist in the identification and education of handicapped children.
5. To help prevent and control disease.
6. To provide emergency service for injury or sudden sickness.

Each of these components is broad and may have varying interpretations as well as applicability. Their applicability is affected by the kinds of health problems that are predominant today. These are different from those of a generation ago and vary among our communities and even from neighborhood to neighborhood in a city. How to carry out these program functions and what meaning they

have for school health personnel will differ widely. Basically they have extensive usefulness.

## *The Need for Change*

However, differences in communities and in health problems are not the only factors which determine the content of a community's school health program. Often these programs continue practices which, though appropriate several decades ago, hardly are effective today since they fail to meet the major challenges of the present generation.

When school medical services started in this country (the first is reported to have begun in Boston in 1894) the control of the spread of contagious and nuisance diseases was the principal objective. This led to medical inspections of children in school. Subsequently major emphasis was placed on examinations for the discovery of physical defects and procedures designed to show parents the need for having these defects corrected. This continues to be the major emphasis in school health services. Such examinations are considered of importance not only for case-finding purposes but also for their usefulness in teaching children basic facts about health and in helping them to develop good health habits. In fact, for many schools, health education is considered the principal reason for having school health services.

Probably the most extensive evaluation of a school health program is the study done in New York City in 1942, known as the Astoria Study.<sup>2</sup> This study



These children are taking an audiometric test for hearing in their classroom. Failure to pass will denote a child's need for further testing and the possibility of his need for medical treatment and special attention from the teacher.

not only pointed out that much wasteful repetitive work was going on, which, year after year, resulted in the recording of more defects, often involving the same children, without adequate follow-up activity, but it also showed the way to a more effective program. The conclusions and recommendations of this study have been widely influential. They are particularly significant for teamwork in that the study demonstrated the effectiveness of the teacher in case finding and the importance of her relationships with the nurse and physician as a member of the school health team.

While not all of the findings of the Astoria Study have equal applicability in all of our communities, several basic questions do. These include:

1. What are the major health problems of children in our community?
2. What priorities should be established in providing health services?
3. What are our community health resources and how effectively do we use them?
4. What is the most productive use of the time of the school doctor, nurse, and teacher?

5. For what children should the school provide physical examinations?
6. How can the effectiveness of follow-up services be increased?
7. What is the relationship of the school guidance program to the school health program?

Answers to such questions as these must be sought both within the school in its policies and administrative procedures and in the relationship of the school to the rest of the community. One administrative question has lately been given increasing attention—that is whether nurses in these programs should more appropriately be employed by schools or health departments.

Many people feel that most school health programs are badly in need of review with respect to their content, procedures, and objectives. Large sums of money are spent in these services, with varying effectiveness. Not enough recognition has been given to the ways in which our health problems have changed. Communicable diseases and other acute conditions are now less important. More attention must be given to the problems accompanying growth and development, adolescence, and handicapping conditions of childhood. This will require increased attention to the functions of the school health team and the most effective use of the team members' time.

### *Medical Examinations*

A brief recapitulation of the history of school physical examinations will illustrate how concepts of school health services have changed, as well as some different points of view regarding them. Twenty-five years ago annual medical inspections of all school children were customary. Subsequently, as education became effective in increasing the public understanding of the importance of controlling communicable and nuisance diseases and of securing medical care early and seeking health supervision for children, the value of medical inspections diminished sharply. Some form of frequent health examination was still considered important in many places, however, and has not yet been given up. As recently as 1945, a law was passed in one State which provides for Statewide biennial medical and dental examinations of all pupils in public and private schools. Examinations of such frequency and such large numbers cannot be done adequately, are wastefully repetitive, and may give many parents

as well as school administrators a false sense of security.

School health studies have demonstrated that effective case finding at less cost can be achieved by having 3 or 4 routine examinations during the 8 school years, with parents present, and using various screening tests and the teacher's observations and her conferences with the nurse for selecting children at other times for referral to the physician. The teacher has been shown to be a good case finder. Moreover, the more parents rely on their own physicians for their children's health examinations, the less will be the need for the school to provide it. The extent to which they do this varies considerably, however, and is related to the family's income.

Such a plan for health examinations has been shown to be effective and less wasteful. It enables the school doctor to serve as a consultant to the school and the school health team to concentrate on the more important health problems and on securing adequate care for the children who need it.

Limiting the frequency of school health examinations in this way has led many people to the conclusion that this means that school-age children need a health examination only three or four times. Actually what it means is that it is not practical or efficient for the school to provide such an examination more often.

Studies have been made in Rochester, N. Y., of the value of the examination of first-grade children. Most of these children had had physical examinations in kindergarten, either at the school or in their own physicians' offices, so that little new was discovered. The value of the routine first-grade examinations was, therefore, questionable so far as Rochester was concerned. In other communities the examination on entering school is often the first a child has had in several years.

In Washington County, Md., 1,103 examinations were done in the school health clinics in a 2-year period. The most prevalent health problems were upper respiratory difficulties and behavior problems. A number of serious conditions were discovered which were unsuspected. These included 5 children with rheumatic heart disease, 4 with congenital heart disease, 3 with acute rheumatic fever, 1 with malignant but curable kidney tumor, and a variety of others. The discovery among 1,100 children of more than a dozen with serious diseases would certainly bear out the value of the school health examination program for this county.

Another aspect of the school health examinations has received insufficient consideration. The scope of the medical examination when done in school has limitations imposed on it by the unavailability of laboratory tests as well as the physical surroundings. It is essentially a medical screening examination. Those children who need further diagnostic services and treatment must seek this elsewhere. Would it not be more practical to have these examinations done in a clinic rather than in the school? If the child does not go to his own physician for examination, the clinic can schedule immediately any laboratory studies or further visits, thereby insuring more prompt and effective follow-up.

### *Screening Tests*

What other health services should be provided in the school? While most people feel that ideally the periodic health examination ought to be done by the child's own doctor, screening tests of vision and hearing are best done in school where children are in groups. Visual acuity in childhood often changes rapidly and, therefore, vision tests should be done annually. The Snellen test and the Massachusetts vision test have been demonstrated to be efficient screening tests that are carried out most economically and rapidly with groups of children.<sup>3</sup> Hearing testing should be done every two years routinely, with repeat tests on children who do not pass.

These two tests are of great importance for many reasons, among which is the fact that a child needs to see and hear reasonably well in order to progress in school. Another reason, especially valid in public health and education, is that large numbers of children are involved. Moreover, with adequate attention, progression of hearing loss can frequently be prevented and normal hearing may be restored. Between 5 and 10 percent of children fail to pass audiometry tests. These children are in need of further attention. Because defective vision and hearing are so prevalent and can be readily discovered by screening tests and corrected or improved, screening examinations are of utmost importance.

Other screening tests may be of value in the school health program. Periodical measurements of height and weight may be useful when interpreted properly, and are, of course, one of the oldest procedures in school health. Consideration should be given to making routine hemoglobin determination at intervals as a measure of nutritional efficiency. There are now simple rapid urine tests for diabetes, a condition, however, which is not common in childhood

and, therefore, questionable for inclusion in a mass screening program. Routine testing for tuberculosis, especially at puberty, should be employed much more widely than at present.

Another screening device as yet little used in school health programs is the pupil's health history as provided by a parent. In medical education much stress is placed on learning to take a good history, because such a history often provides much useful information. In school health work the history does not receive much attention. In reviewing the Pennsylvania school health program recently, the medical advisory panel stated that "a medical history can be devised that will be useful in detecting a number of different ailments, including allergies, epilepsy, diabetes, infected tonsils, rheumatic fever, mental illness, and orthopedic defects." Such a history was developed for adults by Cornell University Medical School. Known as the Cornell Medical Index, it is being successfully used in the outpatient department of the New York Hospital. A similar history, filled out by the parent, was tested in the California school health program, and found to be reliable and useful to the doctors and teachers, who were very favorable in their evaluation of it.

### *Points for Review*

School health examinations include periodic health appraisal, screening tests, and continuous observation by the teacher, with referrals to nurse and physician. This part of the school health program needs objective review so that the most productive use is made of the time of the school health team, and activities of comparatively little value can be reduced or eliminated. The problem of dental caries is an illustration of this:

Dental caries is a condition which is very common and has received a great deal of attention in school health services. Probably 90 percent of children have dental caries. That being so, little is accomplished by frequent dental inspections. It can safely be assumed that every child ought to go to a dentist at least once a year for dental care. Efforts should be directed to getting this done rather than to provide repeated dental inspections.

It is possible to reduce dental caries in children by 40 to 60 percent by adding sodium fluoride to the water supply or by applying it to the teeth periodically. The reduction in the size of the problem through fluoridization, and attention given to education in dental hygiene and helping children get under dental care would be far more productive

than repeated dental inspections. Yet for various reasons there are many delays in changing over to this kind of a program.

School health services staff devote a large part of their time to the follow-up of children who are found to be in need of further diagnostic work and care. Much of this responsibility is assigned to the public-health nurse. This is often one of the weakest parts of the program. How productive the procedure actually is varies considerably and should be analyzed by each program regularly. It is the repeated finding and recording of defects about which nothing gets done that has led to much current concern about school health programs.

Since not all defects are of equal significance, it would seem to be possible to devote time to follow-up on the important ones rather than to all that are recorded. Studies of administrative procedures have resulted in more efficient follow-up. But for the most part the school is dependent on the parents, the child's physician, and other outside resources to provide what is necessary. The extent to which such resources are available and the relationship of the school to them is crucial in this phase of the program. In Philadelphia, of 74,940 reported remediable defects in 1951-52, only 30 percent were treated over a 2-year period. Yet Philadelphia is a city where there are many community health and medical facilities.

It is important that the school health program be administered in close relationship to other health programs in the community and not isolated from them. In Washington County, Md., the program is a joint responsibility of the department of education and the department of health and is regarded as an integral part of the county's organized health service. This has enabled the county to develop a program in which there is a continuity from pre-school health services to services in the school and to several specialized public-health programs. The fact that the Washington County health department has a well-organized hearing-conservation program undoubtedly accounts for the fact that recommendations for follow-up care of 430 children with ear, nose, and throat problems were carried out for 92 percent of the children referred. Of 293 referrals for tonsillectomy and adenoidectomy, 195 were carried out by the conservation-of-hearing program and by private physicians. High rates of successful referrals were achieved with other children as well.

Thus, it is possible to achieve considerable success in follow-up care if this is regarded as sufficiently

important to expend time and money to do it, in a program which is closely coordinated with other community agencies. Studies have been done which demonstrate that the financial status of the family, the availability of community resources, and the level of education of the parents are significant factors in the parents' carrying out the recommendations of the school.

### *For Handicapped Children*

Perhaps in no other aspect of school health work is the need for genuine teamwork so evident as in services for handicapped children.

Many children have disabilities, often of a chronic or permanent nature, which may create problems in obtaining an education. These are the children who are orthopedically handicapped, children with poor sight and hearing, children who have cerebral palsy, heart disease, epilepsy, allergies, diabetes, and other conditions. Most of them can be educated as readily as other children. But many will need some modification of their educational programs if they are to benefit from educational opportunities. It is generally estimated that about 10 percent of children require special education. These include the physically, emotionally, and intellectually handicapped. There are, of course, many more who do not need special education, but do require special attention from time to time.

In 1930 the White House Conference on Child Health and Protection made this recommendation: "A State program for crippled children should be built upon the rights of individuals to an equality of opportunity, especially from the educational viewpoint. Academic education and prevocational and vocational guidance and training adapted to crippled children should be available to them at all times in which they are physically able to receive the same, regardless of the location of their residence. Physical care and education designed to produce self-supporting and useful citizens should be carried on together."

Most handicapped children can be educated in regular classes or in special classes in regular schools. The trend is clearly in this direction. Special classes in day schools are becoming increasingly common. Flexibility in school administration is, of course, requisite. Such schools must have adequate health and guidance services and teachers with training in the education of exceptional children.

Schools can make a further contribution by making some provision for education in the preschool

years. Children with cerebral palsy and children with impaired hearing can benefit greatly by early education. Many so-called deaf preschool children, with a proper diagnosis, a hearing aid, auditory and speech training, and training in lip reading, will get much more out of school if they have the advantages of special training in a nursery school. Such children today are often subjected to needless segregation in a residential school.

Epileptic children on the other hand are commonly excluded from school altogether. Most of them do not need special education, but they do need a chance to go to school with other children, which they usually are able to do. About 75 percent of epileptic seizures can be controlled by medication. Even if a child does have a seizure in class no one is harmed by this if the teacher is calm and helpful. The teacher's attitude will set the stage for the attitudes of the children.

The placement of children in special classes requires expert medical and educational judgment and should be done only after careful diagnostic work. Children who are in special classes should be examined periodically to see whether such placement is still necessary. A review of children in special classes done in New York City revealed that 58 of 182 in sight-conservation and Braille classes, or 31.9 percent, were inappropriately placed. Fifty-four of these were reported to belong in regular classes. In the same study, of 74 children in cardiac classes, 87.9 percent "probably did not require placement in the special classes." The report further states that "modifications of the school program \* \* \* should be individualized in terms of the changing needs of individual children. The primary objective should be to return as many children as possible to regular classes in as short a time as possible."<sup>4</sup>

Another aspect of school health which is receiving increased attention is that of the social and emotional development of children and the problems which sometimes develop. These may be more common today or we may be more interested in them. The teacher is in a good position to recognize attitudes and behavior in younger children which may be suggestive of the later development of delinquency.

More adolescent children are reported by the juvenile courts to be in difficulties than in the past, and this places on us a responsibility for dealing with these problems. The school social worker, or visiting teacher, is concerned principally with children whose behavior, attitudes, or family situation are

such that they require special attention if they are to benefit from their educational opportunities. The school social worker is frequently able to assist the school staff in improving the child's school adjustment. When the pupil is to be referred to community social agencies or comes under the care of the juvenile court, the social worker is involved. This aspect of the school health program is taking on increased significance in many urban areas. Although often considered a part of the guidance program rather than the school health program, little reason exists for continuing to separate them.

### *For Adolescents*

The problems of adolescents are especially pertinent to the health programs in secondary schools. There is a greater interest in adolescence than ever before. In fact some people believe that just as the period of infancy and early childhood formerly received a concentration of attention in pediatrics and public health, so we are now moving toward the adolescent and devoting more time to his problems of growing up and seeking independence in our ever more complex society. In adolescence psychological problems take on greater significance. As teenagers are apt to look elsewhere than to their own parents for guidance, the schools through counselors and others often have an opportunity to be helpful to them.

Many parents are unprepared to cope with the various phases of adolescent development. For many years health workers have emphasized anticipatory guidance for parents of preschool children, but only recently has it been suggested that similar guidance might be offered to parents of pre-adolescent children.

An obstetrician, Dr. Samuel Kirkwood, Commissioner of Health in Massachusetts, recently stated, "Of all times in the life span of a woman, most difficult is this jump from girlhood to womanhood and the responsibilities of physical reproduction. Literally overnight the young girl becomes a totally

different person. She is no longer the same to herself. Her position in the family is as changed as her place in the community. She looks at no one, and no one looks at her, in the same light as before the event of puberty. Our civilization places great restrictions upon her and we give her at best little help in this trying time. Only intelligent, sympathetic support can resolve the conflict of necessary dependence and equally necessary self-assertion which marks this time of life."<sup>5</sup>

The concern of the previous generation of health workers was directed to the problems of maternal and infant mortality. A more positive purpose is expressed by Dr. Kirkwood in his concern for healthy children and healthy families. Many obstetricians and pediatricians today believe that the most strategic time to prepare for satisfactory childbearing and childrearing is during the period of adolescence. In accepting this opinion health services, health education, and health counseling must be coordinated in more effective ways to capture the interest of adolescents in preparing to meet their responsibilities of the future.

Dr. Roswell Gallagher's adolescence clinic in Boston represents a pioneer effort to deal more constructively with the young adults of this age period. Similar clinics are in the process of development elsewhere. Problems of adolescence may well be the major challenge of our generation, just as infant mortality was for the previous one.

<sup>1</sup> School health services. A report of the joint committee on health problems in education. Washington: National Education Association, 1953.

<sup>2</sup> Nyswander, Dorothy B.: Solving school health problems. The Astoria demonstration study. New York: The Commonwealth Fund, 1942.

<sup>3</sup> Crane, Marian M., et al.: Screening school children for visual defects. CB Pub. 345, Washington: U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, 1954.

<sup>4</sup> Wallace, Helen W.; Wrightstone, J. Wayne; Gall, Elena: Special classes for handicapped children. American Journal of Public Health, August 1954.

<sup>5</sup> Kirkwood, Samuel B.: Complete maternity care. American Journal of Public Health, December 1956.

---

**Mental health is not measured by earning capacity, but by happiness capacity.**

*Henry A. Davidson, M. D., in the New England Journal of Medicine, October 3, 1957*

*Some signs of approaching danger  
of which professional persons  
need to be aware in . . .*

## HELPING PARENTS OF HANDICAPPED CHILDREN

ELEANOR S. REID

*Formerly Medical Social Consultant, Hospital School for Severely Handicapped Children,  
State University of Iowa*

**F**EW, IF ANY, parents know instinctively how best to help a handicapped child, and how best to handle the intense feelings of disappointment, guilt and resentment which pour over them when they realize that their child may never walk or talk, or learn, or love as other children do. Learning to live with their handicapped child, and with their feelings about him, imposes upon parents the necessity for tremendous spiritual growth and intellectual understanding. This does not come overnight. Finding out what the child needs and how to give it to him is a slow learning process. Parents need wise and patient guidance if the lesson is to become an integrated part of their thinking and being.

Handicapped children belong to emotionally healthy and mature parents and to neurotic and insecure parents. Most often they belong to average parents who are able to withstand a moderate amount of stress and strain, but who may develop serious problems of adjustment if the stress becomes very great. In other words, the typical parent of a handicapped child is, like most of us, a person who can take just so much and no more. This parent is subject to great emotional strain, which may affect his ability to plan appropriately for his child and himself unless relief in the form of counseling and other professional services is available.

Severely handicapped children do not, like normal children, "just grow." The growth of a normal child is governed by an inner law of development. The child will "just grow"—as a physical being and as a personality—if granted a reasonably favorable physical and emotional environment.

But the inner law of development which governs the growth of a child who was born with cerebral palsy, for example, has lost its reliability. Who, then, knows how it will operate? Certainly not the child's poor parents—at least, not at first. They are apt to be average—not exceptionally bright, not exceptionally slow. They are familiar with the way their average children grow, and they are doing fairly well by them. But what now? Their little girl is 18 months old and she does not even crawl, or say "mama," or feed herself cookies. The doctors say she will probably always be handicapped, but hasten to add that there is much that can be done to help her.

It is that word "much" that does it. Remember, the little girl's parents are the kind of people whose tolerance for stress is just average. They can take so much but no more. And here comes much more—hours of exercises, speech stimulation, assistance in feeding and dressing, plus days and weeks of discouragement and frustration when there seems to be

no tangible reward for such a great investment of effort. The goal? Well perhaps the little girl may, at some far distant day, reach that goal her brothers and sisters achieved without even trying—functional independence.

On whom will the final responsibility for achieving this goal rest? Not on the child alone; only partially on doctors, nurses, social workers, and therapists. It will rest chiefly, in the long run, on the child's parents. They are the ones who must face the major responsibility for stimulating artificially the physical and emotional development of a child whose natural potentialities for development have been disastrously tampered with. No wonder that a handicapped child's parents often say, in one way or another: "This is too much to ask of me."

### *Parents as People*

There are many ways in which parents of handicapped children say "This is too much." Social workers and nurses have heard them all again and again.

When a parent of a handicapped child says, in effect: "But I have my own life to lead," he means that the burden of his handicapped child is becoming too heavy and that he is asking, however indirectly, for help. This reaction to stress is sometimes labeled "parental rejection." On the surface that is what it seems, but the professional person who looks further may find that it is a fairly wholesome response to an almost intolerable pressure.

Twentieth-century American parents who read a great deal about child care in the periodicals are likely to come to the conclusion that our society regards them as less important than their children. Our child-centered culture expects parents to make great sacrifices in order to provide their children with "security"—that "elusive" goal of modern living. So saturated are most of us with the concept of the almightiness of the child, that we recoil when we hear a parent protest: "But I have my own life to live!" When we hear the parent of a handicapped child say this, we recoil further. "How selfish and self-centered can a parent be?" we ask.

A professional person should not be dismayed when a parent of a handicapped child protests: "But I have my own life to live!" After all, he speaks the truth. He is right, and he needs to be told he is right. He cannot be a good parent if he does not have some of the satisfactions and rewards which he needs as an individual in his own right. He cannot give up his whole life for his

handicapped child and expect to be a well-adjusted, self-respecting, contributing member of society.

Professional persons must accept the task of lightening the load for such parents and giving them a chance to be free—free of guilt, remorse, and resentment and free of a 24-hour-a-day schedule of child care and therapy. We can say, in effect: "You do have your own life to lead, and you should be free to lead it. We will help you by sharing the physical burden, by giving you knowledge of why and how this happened so you won't feel so badly about it, and by finding adequate financial assistance for you so that the cost of medical care will not leave you bankrupt."

This approach involves the professional person in a threefold responsibility:

1. Sharing the physical burden may mean helping the parents secure admission for the child to a treatment facility, a hospital school, a special camp, or a day center. In some instances, it may even mean helping the parents to make a decision in favor of permanent institutionalization and acquainting them with appropriate facilities for long-term care. In either event, the professional person must share with the parents a sound knowledge of the resources available for handicapped children and must pave the way toward referral.

2. Supplying the "know-why" and "know-how" involves the professional person in individual or group counseling with the parents, usually over an extended period of time. In some cases, this may require the combined efforts of a professional team, including doctors, psychologists, social workers, and parent-education specialists. It also requires the professional person to participate in public-information campaigns.

3. Securing adequate financial assistance for the care and treatment of a handicapped child means that the professional person will probably have to refer the parents to the services equipped or responsible for meeting their needs. This may be a clinic for crippled children, run under public, semi-public or voluntary auspices, where medical care can be secured free or at low cost; or a local welfare department, service club, or voluntary social agency which can help out with the expense of braces, wheel-chairs, prostheses, or other appliances.

Such services can go far toward restoring to a parent his own life to lead as he sees fit. They do not take from a parent any of the rights or responsi-

bilities which are inherent in his parenthood. They merely give him a little more time, a little more assurance, a little more security, which he can share with his family and his community. Everyone benefits, particularly the handicapped child.

### *Unsure Parents*

Some parents have another way of saying that they need help. They say, "I do not have the patience to work with a handicapped child. I cannot give my little boy what he needs. I am too nervous."

A professional person who looks behind this statement may find that the child's parents are young and unsure of themselves, and that grandma, experienced and very sure of herself, has taken over: she compulsively follows every order the doctor gives; having hours to devote to the child, she decides he might as well live with her and benefit from her determination and devotion; she exercises limbs, she fortifies diets, she stimulates speech; she does everything.

In such a situation, the young parents feel more helpless than ever and decide that they can never be as adequate as they must be to meet the child's needs. They have had so little chance to get to know their own child that he is a stranger to them. They find it increasingly difficult to find a place in their lives for him. Eventually, he is deprived of normal family experiences, his parents feel guilty about their rejection and withdrawal, and grandma continues to overprotect him because of her own need to control and dominate. For this little boy personal relationships are badly snarled. He gets his therapy daily and his vitamins every morning. But he does not know who he is or where he belongs, and his disposition is deplorable.

This illustration does not mean that grandparents are not useful and necessary to the family of a handicapped child. It means, however, that there are grave dangers for the handicapped child inherent in any situation which takes ongoing responsibility away from the natural parents.

A similar situation sometimes develops when a handicapped child is placed in foster care by official authorities because his own parents are neglecting his physical care. Like grandma, the foster parents may be determined to do everything just right. But foster homes often fade fast, since the care of handicapped children is more demanding than many foster parents ever dream. So these children all too often lose their foster parents. Who then takes their place? Who has been growing up to the ongoing

responsibility of meeting their emotional needs? Not the parents—they have no permanent responsibility, and know it.

The truth is, no one has grown up with the problem. The child's own home is lost; the foster home is lost; the child, unfortunately, is probably lost, too. Too late we may recognize the hard, cold fact that half a home of his own is better for the child than no home at all, and that ineffective parents are better than none. The professional person's task is not to find new parents for handicapped children—except in rare instances, substitute parents just don't work out on a long-term basis—but whenever possible to help natural parents with their load so that they will be better able to carry it.

Moral support is what insecure parents need and the offer of concrete services together with recognition that they have a hard row to hoe. Once granted respect by the community and relief from the burden of ignorance and debts under which some of them stagger, these parents often show a remarkable ability to handle responsibility which might once have been taken away from them.

### *Denial of Reality*

There is a third way in which parents of handicapped children tell us that they are beginning to crack under the strain of their responsibility. With what appears to be unrealistic optimism they say, "Billy is doing just fine. We are pleased with his progress."

Denial of reality as a reaction to stress is found among the parents of severely handicapped children, and especially among those whose physically handicapped children are also mentally retarded. During such a child's infancy, his parents may have gradually learned to accept the fact that he is crippled. But this seems to be as far as they can go. As the child advances in chronological age but fails to advance mentally, the parents cannot accept the additional stress of a second disability, and, although they have been told repeatedly that their child is mentally retarded, they say, "We are convinced that our little boy is a bright child. It is only his physical handicap that holds him back."

It is true that the parents of the handicapped must have help. But it must never be given in a patronizing "I know better—now you listen to me" way. In the final analysis, the parents know their child better than the professional person does and they'll probably tell the truth about him if given a chance, for a defense usually crumbles in time before

a truly sympathetic listener. They'll need to be absolutely sure they are not in disrepute for past shortcomings, or that an honest confession will not be used to cut off their access to services. The professional person who understands that "he is doing just fine" is merely a defensive verbal barricade against deeply feared reality and not the expression of an unshakable conviction, will be better able to help.

Of course, there are parents whose denial of reality becomes so extreme that only intensive psychotherapy can help them. The professional person has to find out how severe this reaction is before he can judge whether or not it can be handled successfully without psychiatric help. Nurses and social workers know that they are not competent to treat severely aberrant reactions in the parents they seek to help. But recognition of their limitations should not block them from doing what they can to ease anxiety in deeply disturbed parents. They need never be afraid to listen sympathetically to persons in distress. This may not help, but it will never hurt. Afterwards they will want to consult with a competent psychiatrist about the next step to take.

### *The Hopeless*

Not so different from the unrealistic optimists are the unduly pessimistic parents who say, "It's a lost cause." They are afraid to be hopeful lest their hopes be dashed. Fearing that they cannot sustain the emotional stress of another disappointment, they say, "We expect nothing. If progress occurs in our child, we'll regard it as a miracle."

These parents react to stress with a defeated attitude; they are afraid to keep trying. A professional person should remember that when the parents of a handicapped child sound a note of defeat they are probably trying to defend themselves against an overpowering fear. He should let them know that *he* knows how hard it is to be cheerful in the face of cruel disappointment. But he must turn the focus to the hopeful facts—the child's strengths, his potential for improvement. He should offer services and let the parents know that a treatment center, a hospital school, a speech correctionist, or whatever is needed will share the burden of their fears and help them make appropriate plans for their child's habilitation. In such cases, nothing succeeds like success. When such parents learn about their child's potentialities and about the serv-

ices available and see the child improving under appropriate treatment, the truth frees them of their fear of failure. But always the professional person must remember never to deviate from the truth, never to hold out unjustified hope.

### *Projection and Withdrawal*

There is a fifth way in which parents tell professional persons that they need help. They say: "It was all the doctor's fault. He was careless when the baby was born," or "He should have known I was RII negative. The baby should have been transfused at birth," or "It runs in my husband's family."

Some of these parents are factually right. Some are very wrong. But whatever the facts, they are reacting to stress by projecting blame for the cause of their predicament upon someone else. This relieves them of a sense of full responsibility for their own actions and attitudes, and so stands in the way of their planning a sound program for their child. Such parents need the kind of counseling which can help them express their feelings and free themselves of any sense of guilt they might have in regard to the child's retardation.

There is yet another way in which parents of handicapped children tell professional persons that they need help. They simply do not say a word. They withdraw into their shells and do not talk about their child. They seem ashamed and sometimes even try to hide their imperfect child from the world to avoid embarrassment. Such parents are saying, in their silent way, that they cannot carry the weight of their shame about their inability to produce a normal child. They see their offspring as a product of their own imperfections. The child is a constant reminder of their inadequacy. Lest this inadequacy be paraded before the world, the parents keep themselves and their child from society and the child grows up without normal social experiences.

In its extreme forms, this type of withdrawal indicates deep-seated mental illness. In milder forms, the warm support of a professional person can do much to encourage such parents to make normal social contacts for themselves and their child. "Ego-supportive treatment" is the term social caseworkers use to describe the process which seems to be most helpful in relieving the anxieties of those who tend to withdraw. The parents are warmly approved for any positive steps they make toward regaining

contact with society. They gain confidence in their own worth from the knowledge that their doctors, nurses, and social workers like them, esteem them, and care about them as individuals. With more self-assurance, they begin to appreciate the worth of their child, however handicapped he may be. Having learned to relate in a new way to a person whose friendship offers them longed-for security, they find confidence to face the world.

### ***Guilt Reactions***

Some parents indicate when the strain of their burden is becoming too great by showing feelings of guilt in regard to the child's handicap. "I blame only myself," they say. "It is not the child's fault."

Some of these parents know why they feel guilty. They tell about not having secured proper medical care for a sick baby, or having allowed the child to go swimming during the polio season, or not having followed diet instructions during pregnancy, or having taken the child to a chiropractor instead of to a physician. Others are pervaded through their whole being with a sense of guilt, the source of which they cannot name. The guilty feeling, then, may stem from deeply buried fears of religious or sexual error,

the child's handicap being regarded as a punishment from God for the parents' sins.

To care for a crippled child under a heavy burden of guilt is a heavy task. The guilt-laden parent needs immediate help. He needs counseling, education, services—everything that will help him regard the handicapping condition not as a punishment but as an accident. When his energies are no longer totally invested in inner conflict but free to make plans and find care for the child, then the whole family, including the handicapped child, stand to gain immeasurably.

### ***Parental Attitudes***

These are a few of the ways in which families of handicapped children give warning that they are faltering under their burden and ask for help. Let us hope that the ears of doctors, nurses, and social workers will be tuned to hear the true meaning of what is being said, and that their professional services will be broad enough and flexible enough to meet the needs. For if the families of handicapped children can be salvaged the children can probably be salvaged, too. But if the parents are lost, the cause is lost.

---

## **FILMS ON CHILD LIFE**

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

**KAREN.** 20 minutes, sound, color, rent; in Texas, loan.

Explains each step in using an audiometer to give hearing tests.

**Audience:** Teachers, nurses, and parents or other volunteers learning to give hearing tests.

**Produced by:** Texas State Department of Health, Public Health Education Division, Austin 1, Tex.

**Distributed by:** Same.

**ARTS AND CRAFTS FOR THE SLOW LEARNER.** 27 minutes, sound, black and white, purchase or rent.

Shows various types of manual activities in a public-school class for the

educable mentally retarded—finger painting, woodwork, leathercraft, potato carving, wet-chalk drawing, glass painting, and wood burning.

**Audience:** Teachers and parents of retarded children.

**Produced by:** Nathan Wolfe, Alfred Schmidt, and Melvin Schumacher.

**Distributed by:** SWS Educational Films, 744 North Fuller Avenue, Hollywood 46, Calif.

**EVEN THE LEAST OF THESE.** 12 minutes, sound, color, rent.

Pictures activities in a school for cerebral-palsied children. Shows the kinds of services and equipment needed

in helping these children overcome their handicaps or adjust to them.

**Audience:** Parents; civic groups.

**Produced by:** State College of Washington, under sponsorship of the Eastern Washington Society for Crippled Children.

**Distributed by:** State College of Washington, Audio-Visual Center, Pullman, Wash.

**NO EASY ANSWER.** 18 minutes, sound, black and white, purchase or rent.

Raises questions for group discussion of how Jewish parents can deal with the effects of anti-Semitism on their children.

**Audience:** Parents.

**Produced by:** Anti-Defamation League of B'nai B'rith in cooperation with Department of Child Study, Vassar College.

**Distributed by:** Anti-Defamation League of B'nai B'rith, 212 Fifth Avenue, New York 10, N. Y.

# COORDINATING HEALTH SERVICES FOR HANDICAPPED CHILDREN

HELEN M. WALLACE, M. D.

*Professor of Maternal and Child Health, School of Public Health, University of Minnesota*

**A**LMOST ANY community with a strong interest in fostering rehabilitation of handicapped children eventually faces the problem of coordination of services.

The problem, in fact, actually reflects the vitality of the community's interest, for it exists only where concern for the handicapped has resulted in the provision of a number of services by a variety of agencies. Communities with little interest and consequently few, if any, services have nothing to coordinate.

Handicapped children fall into many diagnostic categories. They include: children with orthopedic, neuromuscular, and neurological problems; children with rheumatic fever or heart disease or both; children with congenital malformations or birth injuries of all types; children with convulsive disorder; children with cleft palate and cleft lip; children with hearing impairment; children with visual defect; children with malocclusion; children with speech defect; children who are mentally retarded; and children who are emotionally disturbed. An increasing number of State or community programs for handicapped children are including children having any type of chronic illness, including, among others, diabetes, nephrosis, asthma, and celiac disease.

With so many diagnostic categories included in the definition, the total number of handicapped children is bound to be large. Accurate data on the number in this country are not available, but conservative estimates put the total at 5,615,000.<sup>1</sup> The largest groups are composed of children with speech defects, orthopedic conditions, mental retardation,

rheumatic fever and heart disease, and hearing impairment.

The types of services needed by handicapped children in any of these categories are also many and varied. They include: (1) early case finding; (2) referral and counseling; (3) evaluation, diagnosis, treatment, and rehabilitation on a team basis with consideration of health, social, psychological, educational, vocational, and recreational aspects; (4) provision of opportunity to continue either in regular school classes, special classes or special schools, or with home teachers, according to the child's condition; (5) provision of vocational testing, guidance, training, and job placement for teen-aged handicapped youth; (6) provision of recreational opportunities, including day programs and camping; (7) provision of foster-home placement for those who need it; (8) provision of home-care help for home-bound children; (9) provision of special housing for some handicapped children and their families; (10) special transportation facilities to enable some children and young people to attend school, recreational programs, treatment services, or work; (11) residential or custodial care for severely disabled children who show no evidence of response to the rehabilitation process over a period of years.

A well-rounded program for the handicapped will also be concerned with the kinds of health and educational programs that can prevent further handicapping conditions from developing either in normal children or in children already handicapped.

Obviously all of these services must be of high caliber if the broad rehabilitation of handicapped children is to be achieved. Moreover, they are as

applicable to children in any one of the diagnostic categories as to those in any other. However, few, if any, of the handicapped children of any diagnostic category will need *all* of the services listed. Some children will need only a few services; others will need many.

### *Why Coordination?*

The association between chronic illness and medical indigency is well known. It means that most low-income families and many middle-income families with handicapped children need assistance at some point in the various stages of their rehabilitation. Therefore, the community must be prepared to carry the financial responsibility from both official and voluntary sources for a large share of the services for the handicapped. While services to handicapped children have a strong fund-raising appeal, nevertheless sufficient funds never seem to be available to do a complete job in all aspects of service for all those needing service.

Care of handicapped children is expensive, particularly where services are developed on a team basis, as is currently recommended. For example, in a service for children with cerebral palsy, an effective team contains these essential members: pediatrician; orthopedist; physiatrist; social worker;

Two children practice motor control through a normal nursery school activity in a pre-school center for cerebral palsied children. Referring parents of handicapped children to suitable services is a first step in helping them.



public-health nurse; physical, occupational, and speech therapists; psychologist; teacher; and vocational counselor. To their services may be added those of an ophthalmologist, neurologist, psychiatrist, and hearing specialists. In a service for children with hearing impairment, a fully staffed team includes: pediatrician; otologist; social worker; public-health nurse; speech therapist; psychologist; teacher; vocational counselor; audiologist; and audiometric technician.

Obviously, for the community to employ a complete team for handicapped children of each type would involve considerable expense as well as duplication, for both teams require some of the same types of personnel. This aggravates a serious problem posed by a scarcity of trained personnel. A recent report of the Health Resources Advisory Committee<sup>2</sup> indicates a shortage of trained personnel exists in practically all of the professions necessary for the rehabilitation of the handicapped. Therefore, from the viewpoint both of conserving funds and reaching as many as possible of the children who need help with the personnel available, joint planning and coordination of services are necessary.

Where there is no joint planning and coordination among the services for handicapped children, continuity of care is not always provided, not all children receive all of the services they need at the time most appropriate for them, and multiple diagnostic work-ups are often performed which are both distressing to the patient and wasteful of professional time.

### *Methods of Coordination*

Agreement on the need for joint planning and coordination of services immediately brings up the question: "What are some possible methods by which coordination can be accomplished?" This can be approached at two levels—community organization and the direct provision of care to the individual child and his family.

Let us look first at the community. For my first two years as director of a crippled children's program in a large metropolis, I spent a considerable amount of time with my staff in looking at the services available, determining unmet needs, and attempting to plan new services to meet those needs. While we managed to secure a great deal of information, we had little or no success in developing new services. This was highly discouraging. However, as we went around to look at the services that were available, we became acquainted with a number of staff members of the four other official agencies and

about 25 to 30 voluntary agencies serving handicapped children. We found that the representatives of most of these agencies had the same types of problems and had recognized many of the same needs that we were beginning to recognize. We also found that each one of us had been trying individually to develop services, with hardly any tangible success. As a result, a meeting of all agencies serving handicapped children was called to see what the group could accomplish together. It turned out to be the first of continuing regular monthly meetings.

At the first meeting, the conferees selected priority items from a long list of unmet needs. Then they went to work through subcommittees, drawing up statements of the need and recommendations for a community plan.

Through this joint planning, the agencies achieved the following accomplishments:

1. A jointly financed study of transportation of the handicapped, which took 6 months. This resulted in the revamping and improvement of the entire method of transporting handicapped children to school.

2. The development of a plan for services for handicapped children of school age, which was the basis of recommendations to the mayor made by a special advisory group appointed by him for the purpose. As a result of these recommendations, services were expanded to enable many more handicapped children to attend school and to receive more complete service at school when they did so.

3. A statement of housing needs of families with handicapped children. This resulted in some priority being given these families in assignment of apartments in new low-cost housing projects.

4. A recommendation that a foster-home program for handicapped children be developed. While the child-placement agencies in the community did not completely follow this recommendation, they did take an increased interest in finding foster-family homes for handicapped children so that more such children were placed in them from hospitals and convalescent homes.

5. A recommendation that the official crippled children's agency pay for outpatient care of handicapped children. Some initial success in this direction has been followed by increased attention to the problem.

6. The development of a plan for a home-care program for the homebound. Implementation of this plan has been impeded by lack of a source of financing.

7. An agreement by the agencies to review together the annual budget request of the official crippled children's agency and to select items in it they wished to support. As a result, representatives appeared at budget hearings to speak in behalf of the request and did a great deal of "behind the scenes" work to get the budget adopted. This support was largely responsible for whatever success was achieved in the development of new services in the official budget.

This particular method of coordination—consisting of monthly meetings of all community agencies concerned with handicapped children, their agreement on the most important unmet needs, their working out of a joint plan, and their pulling together to promote its adoption—was carried out entirely informally. When agencies were asked if they would like to have some official recognition for their joint work, they turned it down on the theory that the informality of their efforts gave them more freedom of operation.

### *Committees and Commissions*

A formal extension of this method, which has met with considerable success, is the establishment of a statewide or community crippled children's commission for handicapped children. Such a commission usually has advisory functions only and is composed of professional and lay persons interested in developing, promoting, and coordinating services for all types of handicapped children.

Another method for coordinating efforts for handicapped children is the establishment of a joint legislative committee on handicapped children, appointed by the Governor and composed of selected legislators, professional personnel, and lay leaders. In New York State a joint legislative committee on cerebral palsy, established at the instigation of United Cerebral Palsy, has accomplished a number of objectives, including appropriations for: a study of the number and needs of children with cerebral palsy; the training of all kinds of professional personnel; grants to institutions giving out-patient care to cerebral-palsied children; expansion of in-patient service in one State institution. The committee annually reviews the service data, caseloads, budgets, and budget requests of the four State de-



A nursery school teacher and a physiotherapist help two children with cerebral palsy learn how to fall without getting hurt. Numerous other specialists complete a team providing coordinated services to such children.

partments of government concerned with cerebral palsy—health, education, welfare, and mental hygiene—and makes recommendations to them.

This council has been in existence 10 years. Because of its success, a movement is on foot now, initiated and spearheaded by the United Cerebral Palsy itself, to broaden the council's concern to include all types of handicapped children.

Still another method of coordinated planning is the use of advisory committees for agencies working with the handicapped. For example, in New York City whenever the official crippled children's program is considering the development of an entirely new service, an official advisory committee is formed, composed of clinical experts, representatives of pertinent voluntary agencies and, at times, lay leaders. Facts about the needs are presented, and a recommended plan for community action is usually developed. In this way, the voluntary agencies are brought into the planning early, duplication of services is avoided, and some coordination of agency services is achieved. The reverse also takes place. In New York many of the voluntary agencies have formed professional advisory committees, of which clinical experts and representatives of the official programs are members.

Such close working relationship means that the official programs are assisted in assuming responsi-

bility for many of the basic routine services while the voluntary agencies, with their greater flexibility, can use more of their funds to try out new ideas and initiate pilot programs. Thus, the community can make progress more quickly in taking care of unmet needs, can reach more children and their families in need of help, and can use the funds available for handicapped children in a sounder way than would otherwise be possible.

Such a close working relationship cannot develop overnight. In New York it came about only as workers in the field came to know each other and to develop mutual trust and respect. It required fostering a feeling of sharing a common goal to displace a feeling of competitiveness.

### *Direct Services*

Now, let us look at what can be done to provide coordinated care to the individual child and his family. During the current century, and especially in the last two decades, interest in specific diseases has resulted in the establishment of so many voluntary organizations on a diagnostic categorical basis that in many communities today services to the handicapped are provided through numerous separate agencies. It is not uncommon to find in one community separate agencies for patients with cerebral palsy, muscular dystrophy, multiple sclerosis, cardiac problems, convulsive disorder, mental retardation, arthritis, and hearing impairment.

The provision of these services for the various kinds of handicapping conditions separately can have a number of undesirable effects. For example, in the care of cerebral-palsied children, it may mean that a cerebral-palsied child suspected of having a hearing impairment will either receive an inadequate hearing evaluation in the cerebral-palsy service or be referred to another agency for hearing service. Or if the same child has convulsions, he may not achieve full control of his seizures through the special cerebral-palsy service and may have to be referred to another agency serving children with convulsive disorders. This would again be true if he had a visual defect or a cleft palate.

Thus, diagnostic fragmentation of services presents the possibility of incomplete evaluations in some instances and of repetition of parts of services in others, and frequently makes it necessary for the child and his family to go from place to place to achieve complete service. For these reasons, as well as to prevent wastage of community funds and of the time and energies of available personnel, it seems

sounder to provide such services through a general multidagnostic, treatment, and rehabilitation agency interested in all types of handicapped children, located in one place and staffed with all the kinds of personnel necessary to meet all the needs of all handicapped children. This approach means that the individual child and his family receive better care, more children are helped, the professional personnel are used more efficiently, and the cost to the community per child is reduced.

### *The Team Approach*

Another coordinating device can be found in the "team approach," a term which has been widely used for years, but not as widely translated into practice.

What can the team approach mean for the individual child and his family? It might mean eventually the difference between an independent and productive young adult on the one hand, and a long-term public-assistance recipient on the other. In other words, in one case, the presence of a vocational counselor as an integral part of a team for handicapped children may mean the application of vocational testing, guidance, training, and placement to the teen-ager at the time when he is most ready for it. In another case, a child who is participating in the rehabilitation process may reach a plateau in his climb toward normality, either because of physical or psychological impediments. The inclusion of a skilled psychologist on the team may make it possible to ascertain the inhibiting factors.

The chances for the child's attaining his maximum potential for rehabilitation will be greatly enhanced if the full team is used for the initial evaluation and for frequent periodic reappraisals. When the team is thus used one member must be designated as responsible for the continuing care of the individual child and his family, to follow the child's progress, and to pull together the team members' various efforts. Without this type of coordination, the team's activities may also be merely fragmented services.

Also important in coordinating services for the individual child and his family is the provision of continuity between care given at a central point, as in an inpatient or outpatient service of a hospital or school, and care at home.

It is not uncommon for a child who has made significant progress on an inpatient service, to regress after returning home. Simple oversights are often behind such regression. The child may have been

provided with a wheelchair which is too wide for the doorways at home. He may have been taught to care for his toilet needs through techniques applicable only in the hospital's toilet facilities and not in those at his home. In order to facilitate proper care at home, the community's public health nursing service can be of great assistance in reporting home conditions to hospital personnel, in preparing the home and family to receive the child, and in helping the family to adopt some of the rehabilitation techniques at home.

Each professional worker has numerous opportunities for promoting coordination of health services. These opportunities occur each time he sees a child who is known to other professional workers, as well as when he participates in complex community planning efforts. It is important to bring to the child the particular service he needs at the time most appropriate for him in relation to his individual growth and development. Unless services are coordinated, obstacles may obstruct this essential factor of proper timing and so prevent the best possible job from being done for him. The goal of coordination of services for handicapped children is the maximum rehabilitation of as many children as possible, using the available professional personnel to their fullest, with the least possible cost to the community.

### *The Import*

With the increased aging of our population, health personnel of all types will in the future be more and more concerned with the care and rehabilitation of adults with chronic illness. Some lessons may be drawn from experience in working with children with chronic disease, so services for chronically ill may not have to go through many of the trial-and-error methods which the children's services have had to do. This not only applies to the problem of coordination of services for adults in the community. It also raises the question of coordination of services for children with chronic illness with the newer services being developed for adults with chronic illness. Anticipating this may help us avoid the complication of the problem by approaching it too late.

<sup>1</sup> Rusk, H. A. and Taylor, E. J.: Physical disability—a national problem. *American Journal of Public Health*, October 1948.

<sup>2</sup> Health Resources Advisory Committee: Mobilization and health manpower. II. A report of the subcommittee on paramedical personnel. *In* Rehabilitation and Care of the Chronically Ill. Washington, D. C.: Office of Defense Mobilization, January 1956.

*Potentialities for rehabilitation  
in training schools lie in . . .*

# THE ROLE OF INFORMAL INMATE GROUPS IN CHANGE OF VALUES

GEORGE H. GROSSER, Ph. D.

*Instructor in Sociology, Queens College, New York*

THE GROUP NATURE of much delinquency is an important point from which to examine the treatment process in training schools for delinquent youth. It reminds us that the behavior of individuals is strongly influenced by their group membership and by the interplay of the various groups to which they belong.

Such a paucity of research data is available from the field of corrections that what I have to say can be presented only as suggestive of researchable hypotheses. My theoretical propositions are drawn largely from experiments carried on in the fields of industrial relations, group dynamics, and small-group research, rather than from the field of corrections.

An individual's adherence to social norms is determined not only by the initial internalization of values but also by interaction with other individuals adhering to the same values. The group, in other words, has a definite effect on the persistence or change of norms which complements the psychodynamic forces working within the individual.

In a training school for juvenile offenders, most of the residents are adolescents. While they are there because of having violated the law, they nevertheless share a large part of the values of society

or at least of society's subcultures. Their delinquent behavior encompasses only a small range of their total behavior. The training school exercises a custodial and reformatory function and, regardless of its philosophy, provides an authoritarian setting. That is, the administration does not exist by or depend on the consent of the residents and is the sole determinant of policy for the institution.

Within the training school an interaction of two groups, the administration and the inmates, is constantly taking place. Between these groups is a line of cleavage defined by a differentiation in status, which is reinforced by the difference in status between delinquents and representatives of the law outside the institution. The integration within one social system of two such different groups, as in an institution, contains many facets not found elsewhere in a democracy:

1. The inmates and the administration are so separate in status that rising from the lower to the higher is an impossibility.
2. While the administration has a specific task orientation, the inmate population does not share this nor have any specific task orientation of its own. Predominantly membership- or group-

"Inmate" is a word generally avoided in reference to children and adolescents. The author uses it in this article to distinguish those for whom the institution exists from those who run it.

This article grew out of a paper presented at an advanced seminar on authoritative settings held at the New York School of Social Work in December 1956. It will be followed in the March-April 1958 issue by another of the same origin, in which Lloyd Ohlin, professor of sociology at the school, describes an experiment in the reduction of role conflict in an institution's staff.

oriented, the inmate population has no group goal which the young people recognize as valid and achievable through their own coordinated efforts. Moreover, both administration and inmate population maintain networks of informal organization among their memberships.<sup>1, 2</sup>

This informal group structure arises out of needs generated within the institution and within the subcultures from which the young people have come. It is based on:

1. Adolescent needs for peer-group relationships, generated by the conflicts that adolescent status in our society produces.
2. The normal tendency for people spending extensive amounts of time together to cluster into informal groups on the basis of affective ties.
3. The need of persons in the same boat for support from one another. In this sense, the inmate social system has many of the aspects of a minority group under stress.
4. The adolescent need for friends of one's own sex in a culture in which heterosexual relations in childhood and adolescence are generally frowned upon.<sup>3</sup>

### *The Role of Informal Groups*

The informal groups tend to maintain their identity, their norms, and their cohesiveness for, since they serve the needs already mentioned, their persistence is consciously and unconsciously striven for by the membership. Some of their mechanisms for survival explicitly threaten or violate discipline in the institution; others do not and therefore are often

considered not particularly noteworthy. On the whole, however, the self-maintenance of the group is synonymous with the maintenance of the value system of its members. This fact tends to defeat the reformatory aims of the institution. This is so even when the groups conform in large measure to the demands of the institution.

Among the mechanisms of group control which these informal groups share with other groups under stress are:

1. Recruitment and screening of membership and transmission of the institutional lore to the newcomer.
2. The development of social norms and rituals—characteristic institutional slang, ritual forms of interaction, the sharing of secrets with respect to illicit activities, and the establishment of a definite hierarchy of leaders and followers.
3. The application of sanctions to violators of the group code, ranging from gossip and ostracism to outright violence.
4. The development of loyalty and group ties.
5. The constant reinforcement of the separateness of the group through an attempt to create an orthodoxy of beliefs. This is done by informal communication, the spreading of news through the grapevine, and biased interpretation of the administration's policy, especially where it concerns the fate of particular group members.

### *Obstacles to Change*

As indicated, the informal groupings in training schools for juvenile delinquents not only fulfill many of the inmates' basic needs but tend to become self-perpetuating with the development of mechanisms of group control and group maintenance. They militate against change in the delinquent's value system and against true rehabilitation of those individuals who throughout their stay remain attached to this type of social organization. In the absence of reliable research data, the author, from personal experience in training schools, would estimate this group as comprising from 30 to 50 percent of the inmate population.

While the obstacles to change differ from person to person, depending upon past experience and character formation, these informal groups in general present conditions which are often hampering to the best efforts of individual therapy. Psychological and sociological research has shown that the stabler

the frame of reference of an individual, the more resistant is he likely to be to a contradictory frame of reference, and that the stability of a frame of reference depends not so much on the individual's own experience and reality testing as it does on group consensus and reinforcement.<sup>4, 5, 6</sup> This reinforcement of an existing frame of reference makes it extremely difficult for an individual to change even when he has considerable ambivalence in his feelings toward his group. The group always has mechanisms for displacing intragroup hostility onto outsiders.

It is, then, not surprising that so many failures occur among training-school alumni. To blame this on the environment to which the delinquent is sent after release is begging the question, for he will select those associations which are congenial to his character and values. It is likely that in many cases the individual, unchanged by his training-school experience, seeks out a delinquent environment upon release.

### *The Task of Change*

The accumulating evidence that persistence and change of norms are not solely a factor of the individual's own personality structure, but also depend on successive group affiliations and on the resolution of conflicting loyalties in these affiliations is of crucial significance for training schools. What seems to work so effectively in the maintenance of antisocial values could, if the theoretical assumptions are sound, also work in the opposite direction. Evidence that the group can effectively change the individual's value system has been produced by a variety of social-psychological experiments in laboratories and a number of studies in actual life situations.<sup>7, 8</sup> The common element in all these studies is that the individual's frame of reference, attitudes, and value system experience a change under group influence if the individual desires acceptance in the group with which he has been brought into contact. Most delinquents who enter training schools want to be accepted by their fellow inmates.

Therefore, if we wish the young person upon his release from the training school to become integrated into a peer group that pursues constructive aims and does not violate the law, we must somehow prepare him in the training school for such group affiliation. A mere environmental change, such as a foster home, will not be sufficient if the individual emerges from the training school unchanged.

Bringing about change, therefore, would require producing within the institution an informal peer group which is not focussed on hostility to the administration and to law-abiding society and to let such a group influence the newcomer. How is such a group to be molded? Can psychotherapy, for instance, achieve this goal?

### *Psychotherapeutic Methods*

Traditional individual therapy is essentially a dyadic relationship. As such, it rests on the transference of the patient's affectional feelings and excludes others from this relationship. The incentive to change which comes from the patient's relationship to the therapist is purely individual. Therefore as far as a group is concerned it constitutes a divisive element. It arouses jealousy and antagonism, suspicion and mistrust.

There is considerable evidence in the literature on institutions that the informal social group distrusts and resents individual therapy and that this resentment is in direct proportion to the strength of the group's hostility towards the administration and of the need for social cohesion aroused by its members' defensiveness. The effect of intensive individual psychotherapy is to separate the patient from the informal group, since a motivation stronger than group influence has set in and the identification with the therapist replaces identification with group members and leaders. Such a relationship seems to be achieved more successfully with individuals whose group loyalty to the informal inmate organization is not particularly strong to begin with, and who, because of specific neurotic problems, have always moved on the fringes of the informal group. With those group members who maintain a very strong loyalty to their informal peer group, individual therapy is very often, though by no means always, ineffective.

In general, individual therapy tends to weaken the informal organization and atomize its membership. Since it cannot be effectively provided to all, partly because it promises no success in some cases, partly for economic reasons, it cannot be expected to change group values.

As limitations of individual therapy have become recognized, group therapy has been called upon to fill in the gaps. However, it too has its limitations.

The beneficial effects of group therapy on withdrawn individuals, some types of alcoholics, and other isolates, have raised expectations for this type

of treatment which, in the case of juvenile delinquents, have not as yet been fulfilled. The most important misconception of the applicability of certain forms of group therapy seems to lie in the failure to understand that in the case of many a delinquent the need is neither to foster his integration into his peer group nor to help him overcome a sense of isolation. Indeed, the average individual in a State training school, whatever his personality difficulties, shares a value system and considerable degree of intimacy with like-minded individuals. It is, perhaps, precisely for the sake of this sharing that he has entered into delinquent activity. Therefore, the traditional form of group psychotherapy, which is supposed to effect reorientation of an individual to his society, misses the mark, creates a conflict between the members of the informal social group, and tends to isolate the patient rather than help him integrate into nondelinquent society.

A more hopeful version of the process, called guided group interaction, has been tried out by McCorkle, Bixby, and others.<sup>9</sup> Its aims and mode of attack seem more likely to satisfy the conditions necessary for changing group, and hence individual, values. How effective it can be is not as yet clearly apparent, but very likely with a group of selected individuals, on a very small scale, as in the current Highfields project, it can succeed. At Highfields, an experimental institution in New Jersey, the individuals are there for such a short time that they hardly have time to become strongly attached to an informal group structure. While this experiment may ultimately be of use, the method is not practicable within the framework of most training schools as set up now.

While efforts at both individual and group psychotherapy can be useful within institutions, their effectiveness is limited by the institutional setting and the varieties of individual personalities it includes.

### *Carriers of Change*

Historical and experimental evidence amassed during the past few years points to the potentialities of the social group as an effector of change in values. Evidence from industrial relations, the armed forces, religious sects, and small-group research indicates a way to the development of hypotheses suitable for testing in correctional settings. The following are only a few of the propositions that seem particularly relevant:

1. Changes in the attitudes and values of group members are directly related to the needs that can thereby be fulfilled. Therefore, if recognized needs can be envisaged as better met by a change in group goals or values, the group is likely to change.
2. Such changes are the more effective the more the members have participated in formulating and discussing them.
3. Value changes in organized groups are more effective if the group is definitely task-oriented and if clear-cut communication and understanding exist concerning the goal to be reached and the means whereby it is to be reached.
4. Change in values of group members is positively correlated with a lack of competitiveness and conflict within the group.
5. Change is related to the degree in which each individual sees that his effort is needed for the achievement of the common goal or the maintenance of his standing within the group.
6. Changes of attitudes and values are more likely to occur through group goals set through the group's own motivation rather than imposed from outside the group, and are less likely to occur through goals dictated by an out-group with which the in-group is in conflict.

### *Steps Toward Change*

Among the suggestions for training schools that can be derived from these propositions are the following:

1. Ways might be explored for making the institutional population's informal organization, as well as the individual, more task-oriented. In other words, attempts might be made to discover what other goals, especially group goals, aside from the goal of release from the institution, can be explicitly fostered and achieved by the population of the training school. This is an exceedingly complicated problem but one well deserving of exploration, for the aimlessness of life in many an institution contributes many undesirable features to the informal social organization.

The possibilities of task orientation are not exhausted by industrial work or work in the ordinary sense of the word. These possibilities include well-defined group goals and an array of means to their achievement. General goals enunciated by the administration as, "We are here to learn to live to

gether," or, "We should learn to get along with our fellow man," are not task-oriented in the sense referred to here. Parenthetically, task orientation among adolescent groups in general is a pressing need in present-day society, and if made part of a delinquency prevention program might well have strong beneficial effects.

2. Since the breaking up of informal organization is difficult to achieve, and even when achieved may not be very beneficial because of the resulting individual isolation, means might be explored for lessening the social distance between the administration and the informal social groupings.

If the adolescent in a training school is eventually to live as a part of law-abiding society he must be able to see himself in a role accepted by law-abiding society. The greater the distance between administration and institutional population the less likely are the young people's groups to change in a desirable direction.

The process of reducing social distance between administration and institutional population is not as difficult in respect to adolescents as to adults. Even the delinquent adolescent leans toward accepting the leadership and ascendancy of older persons because he has his dependency needs and because general cultural patterns tend in this direction. For the administration to share experiences with the informal organization and to recognize its position may be one way of lessening social distance.

3. Reward systems might be developed for group rather than individual performance. Group incentive will become easier to stimulate as a more task-oriented group life is developed in institutions. The present system of individual rewards tends to foster isolation and to leave the more antagonistic group members untouched.

4. Use of the existing group leadership to foster change within the group might also be explored. Leaders are generally considered troublesome because the direction in which they assert their leadership more often than not runs counter to the aims of the administration. However, just as informal groups are part and parcel of any large-scale organization, so are informal group leaders. Since they play an important part in maintaining group cohesiveness and fostering group identifica-

tion they can be key figures in an attempt to utilize the group for effecting change of individual values.

5. Finally, since many group members might be amenable to therapy, informal groups might be made the units of therapy rather than artificially formed groups based on individual selection. While Slavson and others have suggested that the usual type of group therapy is counterindicated for certain types of character disorders,<sup>10</sup> a more directive form, such as guided group interaction, utilizing the informal grouping might be helpful in changing group goals. This could be followed up by a more traditional type of therapy, group or individual, for some persons.

### *In Summary*

It seems, then, that the informal groups which emerge in a training-school population might be made to serve important retraining functions if properly utilized. This suggestion is based on the observations that much delinquent behavior is group behavior and that the social group is a crucial agent in the maintenance or change of the value systems of its constituent members. A better understanding of the group dynamics within a training school may serve to make it a more effective agency in the retraining of juvenile offenders.

<sup>1</sup> Clemmer, Donald: *The prison community*. Boston: Christopher Publishing House, 1940.

<sup>2</sup> Hayner, Norman S.; Ash, Ellis: *The prison as a community*. *American Sociological Review*, June 1939. (Pp. 362-369.)

<sup>3</sup> Buxbaum, Edith: *Transference and group formation in children and adolescents*. In *Psychoanalytic study of the child*, Vol. I, New York: International Universities Press, Inc., 1945.

<sup>4</sup> Sherif, Muzafer: *The psychology of social norms*. New York: Harper & Bros., 1936.

<sup>5</sup> Asch, S. E.: *Effects of group pressure upon the modification and distortion of judgments*. In *Group dynamics: research and theory*. Cartwright, D.; Zander, A., editors. Evanston, Ill.; Row, Peterson & Co., 1935.

<sup>6</sup> Newcomb, T. M.: *Attitude development as a function of reference groups: the Bennington study*. In *Readings of social psychology*. Swanson, Guy E.; Newcomb, T. M.; Hartley, E. L., editors. New York: Henry Holt & Co., 1952.

<sup>7</sup> Lewin, Kurt: *Group decision and social change*. In *Readings in social psychology*. Swanson, Guy E.; Newcomb, T. M.; Hartley, E. L., editors. New York: Henry Holt & Co., 1952.

<sup>8</sup> Stouffer, S. A., et al.: *The American soldier*, Vol. II. Princeton, N. J.: Princeton University Press, 1949.

<sup>9</sup> Bixby, F. Lowell; McCorkle, Lloyd W.: *Guided group interaction in correction work*. *American Sociological Review*, August 1951. (pp. 455-459.)

<sup>10</sup> Slavson, S. R.: *The practice of group therapy*. New York: International Universities Press, 1947.

# CHANGE IS THE WAY OF LIFE

MURIEL W. BROWN, Ph. D.

*Parent Education Specialist, Children's Bureau*

A COMMUNICATIONS officer in Alaska may have been the first to see it after it left the earth—"a spark of warm orange" in the northern sky at dawn—a little mechanical ball spinning around our startled planet, listening for secrets in outer space, beeping these back as it bustled along, putting us on notice that the world as we have known it will never be the same again.

Will the experiences which the Space Age has in store for us be so strange, so different, that we cannot relate them in any logical fashion to familiar values, forms of life, and ways of living? Or do we, perhaps, have a scientific frame of reference which will help us to adjust our feeling and our thinking to this boundlessness with some degree of understanding and control?

The International Geophysical Year is an imaginative attempt to establish such an integrative framework for the physical, biological, and to a certain extent the social sciences. The work now being done in a number of research centers toward a general theory for the behavioral sciences is another approach, from a somewhat different direction. More or less closely related to these major programs are a growing number of smaller projects of an interdisciplinary nature which explore the underlying logical relationships within and between systems of ideas.

An interesting example of such a project is the conference on the meaning of development convened in 1955 by the University of Minnesota. The proceedings of this colloquium have recently been published in the book which is the subject of this review: *The Concept of Development*, edited by Dale B. Harris.<sup>1</sup> Contributors to this volume are

scientists, scholars, or practitioners in the behavioral sciences and related professional fields. They were asked "to state the concept [of development] in their own terms and to assess its usefulness to their fields as they saw it."

Development, the first author, the philosopher Ernest Nagel, points out, is a word with protean meanings. Originally a biological term, it has been freely used to describe the changes which take place over time in such different organizations as language, historical movements, societies, the human personality, systems of thought, and bodies of knowledge.

It is therefore important to know to what extent scientists agree upon a definition of it and upon the nature of the processes involved. We must know, further, what types of research are most needed to bridge gaps in our present understanding of these processes; what disciplines or combinations of disciplines should undertake these researches; and how developmental theory can help us to deal more intelligently with change in a world full of unsolved problems.

At the Minnesota conference, it was assumed that development is process, not end product; that development and change are not the same thing; that it is more important to understand what happens in the course of development than to limit the scope of the concept by too precise definition. Certain assumptions were also made with respect to the process itself: That development takes place within systems which have definite structures and definite sets of pre-existing capacities; that it involves the organization of elements or parts within these systems into larger functional units or wholes; that it pro-

gresses by means of sequential changes which contribute to the generation of other, describable systems of things, or properties of things; that it takes place over time.

Within this frame of reference, each author deals ably with the topic assigned to him. More than this, each draws from his own field insights and findings which suggest new ways of looking at problems of common concern. It is especially interesting to see what happens in this series of papers to four questions which appear to have intrigued all members of the conference: To what extent does heredity determine development? How much is now known about the dynamics of development? Can the concept be transferred from the biological to the social sciences and still make sense? How can progress in development be evaluated?

### *Determinism and Differentiation*

Ernest Nagel opens the discussion of the first one: Determinism, he believes, "merely expresses in general form that component in the meaning of development which connects the outcome of developmental process with antecedent structure and latent capacity." The intimate nature of these connections is not known, and the question of how to account for the emergence of new traits and new levels of organization in the course of organic development cannot be answered in terms of any one of the major theories so far advanced. But new ways of looking at developmental theory may enable us to understand "the conditions, whatever these may be, under which growth of human personality is possible and under which the scope of moral choice may be enlarged."

There is considerable support in all of these papers for Nagel's position. The educationist in the group, Willard Olson, calls attention to the change in genetic theory from the older concept of single genes bearing corresponding hereditary characters to the polygene with many different factors. Interaction between these multifactorial genes starts in the sperm and in the egg before they ever meet and continues in the cells of the new organism as long as the latter is alive, constantly creating new possibilities for subsequent development.

The geneticist, J. P. Scott, notes that functional differentiation and variability are the two principal concepts of genetics; that as soon as a part becomes functional its further differentiation tends to modify its own activity; that it is habit formation rather than heredity which tends to put behavior in a straitjacket; that heredity only makes

more probable the type of behavior which will be fixed by habit formation in any given situation.

How much is really known about the dynamics of development? No one of the authors deals systematically with this second question but all are preoccupied with it in one way or another.

Heinz Werner, a comparative psychologist, looks again at an old controversial issue: continuity vs. discontinuity in development. He sees no reason to suppose that all developmental change must be continuous. "Underlying the increase in differentiation," he writes, "are the forms and processes which undergo two main kinds of changes: (a) quantitative changes which are either gradual or abrupt, and (b) qualitative changes which, by their very nature, are discontinuous. . . . This opens the way for a developmental study of human behavior not only in terms of universal sequence, but also in terms of individual variations, that is, in terms of growth seen as a branching out process of specialization or aberration."

Robert R. Sears, also a psychologist, feels the need for an entirely new approach to the study of developmental change. To replace older classifications which "sliced behavior into meaningless and entirely arbitrary segments," he offers a new system for analyzing behavior, a system which deals with the action of the person as a whole. The new dimensions proposed are: (a) changes in the degree of precision, efficiency, and speed with which manipulative, locomotor, and communicative acts are performed; (b) changes in the complexity of the stimuli which can evoke effective interaction with the environment; (c) changes in the length and complexity of the action sequences a person uses in relating himself to his environment and securing gratification for his desires; (d) changes in the quality and complexity of the environmental events that are the apparent objectives (or incentives) of action.

Sears discusses three "general sources of influence" by which these changes are brought about: learning, physical maturation, and expectancies for action expressed to the individual by others. Each of these, he says, are "whole fields of scientific investigation."

### *Points of Choice*

All guidance rests on the assumption that increasing knowledge of the dynamics of development will lead to the conservation of growth potential. In discussing this point, John E. Anderson speaks of the original fluidity of all young organisms, of their

inherent capacity to respond selectively to stimulation from their environments, of the tremendous importance of these selections because of the extent to which each one determines what happens next.

"Once a choice is made," he says, "cumulative and irreversible changes take place which determine the major aspects of subsequent form . . . In his life, the growing individual meets successively many choice points at which decisions between alternatives are made . . ."

The study of these "choice points" offers a rich field for research. Which are the most critical for future personality development? Where do these come in the major developmental sequences? What factors other than chance influence results at moments of decision? Can some or all of them be modified? Under what circumstances? To what extent?

These questions suggest certain implications which were nowhere made explicit in this absorbing book. For human beings, the most powerful factors affecting decisions at "choice points" are unquestionably human relationships. In their study of these, the social scientists are often at a disadvantage. Their traditionally horizontal, cross-sectional approaches may report what is, but seldom show—much less explain—developmental sequences in human interaction. But if developmental theory can be applied to the study of human relations, the way is open for teamwork in which scientists from many different fields can participate.

And why not? If, as these authors maintain, stimulation is essential for all development, then it must be possible to regard the relation between any two or more organisms as a dynamic system of reciprocal stimulation, an evolving system of stimulus-response patterns which grow and change in accordance with the principles of emergent differentiation.

### *Human Relationships*

It is truly exciting to think that some day we may be able to trace the life histories of the basic human relationships, to learn what each can actually contribute to the growth and development of the individual human being, to find out how the potentialities of each can best be realized.

Our present preoccupation with the mother-child relationship illustrates very well the need for such information. Everyone is for mother love. But how much do we really know about it? Where does it come from? When does it begin to grow? How does it grow? What is its role in the total develop-

ment of mother and child? If a baby loses his mother, who else can help him achieve which of the developmental goals of infancy? early childhood? later childhood? How?

A research design comprehensive enough to provide answers to such questions would be a combination of cross-sectional and longitudinal studies in many different fields. It would bring into meaningful relation contributions as different as Lehrman's analysis of parental feeding behavior in the ring dove, Sears' theoretical analysis of the way in which the young human child establishes his identification with his mother, and Erik Erikson's concept of stages in personality development.<sup>2</sup> It would certainly also include yet-to-be-discovered methods of investigating the beginnings of symbolization in infancy.

### *Scientific Methods*

This application of developmental theory to human relationships leads directly to the third of the questions posed at the beginning of this review: Can the concept of development be transferred from biology, where it originated, to other scientific fields and still make sense? Several chapters in *The Concept of Development* focus on this point, particularly those contributed by Norman J. DeWitt, Herbert Heaton and Robert F. Spencer for the humanities and the social sciences; by John A. Anderson, Hyman S. Lippman, John C. Kidneigh, and Willard C. Olson for pediatrics, psychiatry, social work, and education.

DeWitt, a linguist, observes that many people today seem to be moving from uncritical faith in the scientific method to awareness that information produced by systematic inquiry may be true but limited. We do figurative thinking, he says, when we use organic concepts outside of the field of biology. It is safer to test their application in child development than in history, for example, because child development is evolutionary, and the evolutionary process makes no firm commitments. Heaton, a historian, illustrates, with delightful humor, some of the pitfalls in application of development theory in his field.

The concern of the anthropologist, according to Spencer, is to explain man's growth and spread throughout the world, his cultures and his institutions; to find a frame of reference which includes both primitive and civilized man. "Cultures do seem to possess energy and vitality and each to undergo its own evolutionary course," he says. "What the

development of each has been, what it shares in common with others, what it has derived from others, aid in the understanding of man at large. This is the basis of man's perspective on himself."

But how does man gain this perspective on himself? How can progress in development be estimated, evaluated? This is a question that seems to echo through many of the pages of this book. The problem is, of course, to find methods of appraisal which can cope with the infinite complexity of life at every stage of the growth and development of every living thing. There is, among these scientists, more than a little concern about certain tendencies in regard to tests and measurements today which seem to them unsound: the tendency to confuse "measurement" with "evaluation," the tendency to overestimate the importance of statistical frequencies, the tendency to overemphasize quantification, the tendency to misrepresent the meaning of "norms."

Werner points out that "the same achievement may be reached by operations genetically quite different. An analysis of types of operations rather than measurement merely in terms of accuracy of performance often reveals the truer developmental picture."

Efforts to establish norms for the evaluation of developmental progress have been, on the whole, disappointing. As Werner also points out, individual differences are obscured when developmental-achievement scores of individuals are averaged to secure a composite curve.

John A. Anderson describes the problems pediatricians have had, over the years, in finding sound criteria by which to appraise the health of children. The early normative anatomical data—height-weight charts, etc.—soon proved inadequate. Variations within age groups were often greater than the differences between adjoining age groups.

Longitudinal studies of children from birth to maturity were more helpful. They revealed individual patterns of physical growth. When used as a basis for prediction, however, they also were often misleading. Children seemed to change, sometimes, in their capacity to develop.

Gradually it became clear, Dr. Anderson says, that "reference to one or a few features of the growth and development were inadequate to define the child as a whole." Interest in defining the meaning of the "total child," he points out, has led naturally to a deeper appreciation of individuality, of the importance of evaluating growth and development in terms of the emerging potentialities of each individual child. Competent statistical analysis of these individual longitudinal growth patterns can show likenesses and differences in rate and quality of development, can even produce norms which can be checked by cross-sectional studies.

For scientists, parents, members of the service professions, and the hypothetical man in the street, developmental theory makes wonderful sense. It assumes that change is the way of life. It gives us the concept of change points as choice points, a fact which has tremendous significance for education. It stresses, above everything else, the profound significance of individuality—of the creative potential in the individual human being. It is infinitely reassuring in times of great change because, even in the most difficult situations, there is always the possibility that new elements will emerge which can be constructively used in the ever ongoing process of creative problem-solving. This is the "open-endedness" of life, our basic security for the Space Age or any other.

<sup>1</sup> Harris, Dale B. (editor): *The concept of development; an issue in the study of human behavior*. Minneapolis: University of Minnesota Press, 1957.

<sup>2</sup> Witmer, Helen L.; Kotinsky, Ruth (editors): *Personality in the making*. New York: Harper and Bros., 1952. (p. 6.)

---

"If administration exists without a mission, it is merely a method for efficiency but without . . . spiritual motivation as to the reasons why it is important that we become efficient."

*Robert F. Ott, Director, Division of Child Guardianship, Massachusetts State Department of Public Welfare, at the 1957 annual meeting of the Child Care Council of the United Community Services of Metropolitan Boston*

## BOOK NOTES

**COUNSELING AND PSYCHOTHERAPY WITH THE MENTALLY RETARDED;** a book of readings. Edited by Chalmers L. Stacey and Manfred F. DeMartino. Foreword by Seymour B. Sarason. Free Press, Glencoe, Ill. 1947. 478 pp. \$7.50.

About 50 brief papers are included in this book, which is planned as a text for courses on therapy with the retarded as well as a supplement in general courses dealing with psychotherapy.

A section consisting of three papers is devoted to psychoanalytic methods of treatment. Other sections take up group therapy, play therapy, psychodrama, speech therapy, and vocational-occupational-industrial therapy. Eleven papers treat various aspects of counseling parents of retarded children.

The editors expect the book to be useful to a number of types of workers—counselors, therapists, psychologists, psychiatrists, general medical practitioners, pediatricians, social workers, and institutional workers, as well as to parents of the mentally retarded and others interested in the treatment of retardation.

### EDUCATING GIFTED CHILDREN.

Robert F. DeHaan and Robert J. Havighurst. University of Chicago Press, Chicago 37. 276 pp. \$5.

In planning a school program for gifted children in a medium-sized community, the authors, a professor of psychology and a professor of education, suggest that for this purpose children may be considered suitable for such a program if they are in the highest 10 percent of their age group in one or more specified areas—intellectual ability, creative thinking, scientific ability, social leadership, mechanical skills, and talent in the fine arts. Excluded from this program would be the extremely gifted children—the one-tenth of one percent at the top of the group—for whose education a separate chapter suggests methods.

The book describes methods of identifying gifted children and for develop-

ing their abilities through such devices as enrichment of the curriculum, special groupings, and acceleration through the school grades. It emphasizes the importance of understanding the child's motivations for learning and of developing his creativity and special talents. In the planning and operating of such a program, the authors note, the local community's interest and support are needed.

**WITH ALL DELIBERATE SPEED;** segregation-desegregation in southern schools. Edited by Don Shoemaker. Harper and Brothers, New York. 1957. 239 pp. \$3.50.

Shortly after the Supreme Court decided the school-segregation cases on May 17, 1954, the Southern Educational Reporting Service undertook to publish "Southern School News" for the purpose of providing interested parties with factual information regarding desegregation efforts in Southern schools. "With All Deliberate Speed" is a summary of the first 3 years of progress, edited by the executive director of SERS and prepared by members of the "Southern School News" staff, a jurist and an educator.

The opening chapter reviews the legal aspects of desegregation: the history of the school segregation cases; subsequent litigation; judicial resistance to the Supreme Court decision; and evasive legislation. The book then presents the conflict within the Southern States, largely between the Citizens Councils and the National Association for the Advancement of Colored People, to determine whether compliance or defiance of the Supreme Court should be the attitude adopted by school authorities. It also discusses disagreement within religious bodies, labor and industry, and the press regarding the proper path to take. Next comes a review of conflicts over desegregation in a number of specific communities.

Several chapters examine development in border States, in cities, and in the Deep South, in an effort to find reasons for dissimilarities in reactions, in-

cluding the political implications of segregation.

Two chapters contain studies of the process of desegregation in the District of Columbia and in institutions of higher learning in the South. The final section describes the problems of school administrators and board officials in the midst of the conflicts over methods, policies, irreconcilable State legislation and Federal court decisions, academic freedom, and the like.

**RADIATION:** what it is and how it affects you. Jack Schubert and Ralph E. Lapp. Viking Press, New York. 1957. 314 pp. \$3.95.

As part of a detailed explanation of the hazards of radiation, the authors, one a biologist and chemist, the other an atomic physicist, present a chapter on excessive exposures of children to radiation. They point to some of the reasons why radiation exposure is exceptionally hazardous to young, growing persons: (1) Their tissues are generally more responsive to radiation effects than are those of adults; (2) their long life expectancy permits more damage to be caused by long-delayed radiation-induced injury than could be done to an adult by the same amount of radiation; (3) the accumulation of doses to children's reproductive organs increases the chances of passing on hereditary defects to their descendants.

The authors note that overuse of radiation has not decreased since the 1940's, when information on the hazards became widespread, but has actually increased.

A chapter on biological effects of radiation quotes from the reports of the National Academy of Sciences' Committee on Genetic Effects of Atomic Radiation and of the British Research Council to point out the possibilities of hereditary mental and physical defects occurring in future generations as a result of excessive radiation in present-day parents.

**PREGNANCY AND BIRTH;** a book for expectant parents. Alan F. Guttmacher, Viking Press, New York. 1957. 335 pp. \$4.50.

Addressed to laymen, this book discusses conception, pregnancy, delivery, convalescence after confinement, the postpartum examination, and a number of questions in regard to the newborn child.

# HERE AND THERE

## *Biregional Conference on Children and Youth*

The first biregional conference of State planning commissions for children and youth was held in Memphis, Tenn., in mid-November under the joint sponsorship of the Louisiana Youth Commission, the Tennessee Commission on Youth Guidance, and the Children's Bureau. Representatives of the Mississippi, Florida, Alabama, Arkansas, Texas and New Mexico State commissions joined the members and staffs of the Tennessee and Louisiana commissions for a 2-day discussion of mutual problems and of methods found effective in statewide planning for children and youth.

The Chief of the Children's Bureau, Katherine B. Oettinger, set the stage for the discussions by outlining the following criteria for effective planning: inclusion of all groups concerned with the problem; a foundation in current facts; flexibility; democratic procedures; provision for continuous evaluation.

The working sessions considered the following questions which had been submitted by the commissions.

1. What is the best means of rehabilitating a child in the community upon his return from a training school?
2. What programs are needed for mentally retarded children who get into trouble?
3. How can a youth commission effectively follow through on a problem it has identified and studied?
4. To what degree can or should a State planning group coordinate the planning of all services for children and youth?
5. How can a planning group achieve effective youth participation?
6. How can commissions most effectively use public hearings as a technique in studying problems relating to children and youth?

The first question was discussed from the standpoints both of legal responsibility and needed services.

Should authority during the period of parole rest with the court which committed the child or the institution which paroled him? These facts were considered relevant: while courts are closer to the community, a wide range in quality of care exists among them; on the other hand, workers attached to the State training school are not accessible for continuing an emergency service in the community, nor can they keep in touch with community developments which influence the parolee's activities. The discussants agreed that while rehabilitation should have taken place by the time the youth is paroled, actually this is rarely the case since adequate psychiatric services are not available in the training schools to carry out the curative process, and few, if any, communities have programs which provide services to the family to prepare for the child's return.

The acknowledged lack of comprehensive services led the group into a discussion of coordinated planning for all services. It was the consensus that every resource must be tapped and that prior to approaching official appropriating bodies organizations reach an agreement among themselves so that their requests reinforce rather than compete with each other.

In discussing methods of achieving effective youth participation in statewide planning, the conferees came to the conclusion that the adults must define what they expect young people to contribute. In most communities, it was pointed out, a formula must still be found for channeling the large amount of youth participation in a wide range of activities into effective participation in State and national planning. Representatives of other commissions told about extensive youth participation in conferences and annual meetings. It was pointed out that the appropriate training ground for such participation is the local community, with opportunities for increasing responsibilities as experience accumulates.

The Tennessee Youth Guidance Com-

mission reported the use of public hearings throughout the State as a means of factfinding on a selected subject and interpreting the Commission's function. Representatives of two other commissions, reporting that their State statutes give them the right to hold public hearings, recommended that formal hearings be reserved for crucial issues and that other purposes be carried out through studies, forums, and informal public meetings.

## *Indian Youth*

Some 200 people met in Washington late in November for a 2-day conference on American Indian Youth, held under the sponsorship of Arrow, Inc., a non-profit organization of Indians and non-Indians dedicated to helping Indians to improve their conditions. Among them were representatives of 57 tribes and intertribal organizations, including 25 young people of high-school or college age. Also present were a number of resource people from voluntary and Federal agencies, including the Departments of Labor, the Interior, and Health, Education, and Welfare.

A feature of the conference was a panel discussion in which five of the young people, from various tribes, expressed their concern about conditions among youth on the reservations and tried to find solutions. They identified three major problems: (1) juvenile delinquency; (2) excessive drinking; (3) failure to secure higher education. They reported on their difficulties and successes in forming youth organizations or projects within their own tribes after returning from a regional conference on Indian youth held at Fort Thompson, S. Dak., last spring under the auspices of the University of South Dakota.

Five work groups at the Washington conference brought in numerous recommendations. Among them were included: establishment of high-school and college scholarships for Indians by the tribes themselves, the Federal Government, foundations, churches, and labor and industrial groups; formation of tribal committees on Indian youth; encouragement by Federal, State and nongovernmental agencies of Indian youth organizations and efforts to meet the recreational needs of youth on the reservations; the conducting by Arrow and official agencies of research in regard to Indian youth,

especially in relation to their recreational needs, the reasons for their low high-school and college enrollment, the social and psychological conditions of their environment, their health, and the resources available to meet their needs.

The conferees recommended that a similar conference be held in 1958.

### Public Health

The Food and Drug Administration of the Department of Health, Education, and Welfare and the Federal Trade Commission have both announced their intention to take prompt action if any manufacturers make false and misleading claims that their products are effective in preventing or treating Asian influenza. In the announcement the FDA quoted a statement by the Public Health Service that years of extensive research and laboratory investigation have shown that inoculation with vaccine is the only reliable means of preventing influenza. However, the PHS added, some drug preparations will relieve some of the discomforts of influenza, and these have a proper place in a physician's treatment of the disease.

...

Some 160 public-health projects are planned for 1958 by health administrations in the 21 American Republics, to be conducted in collaboration with the Pan American Sanitary Bureau, regional office of the World Health Organization in the Western Hemisphere. WHO has adopted a budget of \$3 million to carry on this work, an increase of \$600,000 over the 1957 budget. The program will emphasize eradication of malaria, yellow fever, smallpox, and other communicable diseases; strengthening of national health services; chronic diseases; occupational health; food and drug services; and the implications of nuclear energy for public health.

...

Twenty-four representatives of health professions, insurance organizations, safety interests, labor, industry, and other users of health statistics have been named by the Surgeon General of the U. S. Public Health Service as members of an advisory committee for the U. S. National Health Survey. The Survey is a continuing program under which the Public Health Service makes surveys and studies to deter-

mine the extent of illness and disability in the population and to gather related information. Household interviews with a nationwide sample of the population are now being conducted.

...

A Commission on Health Careers was formed recently by the National Health Council to plan ways to meet the need for additional qualified health personnel in the United States.

The commission will add impetus to existing local, regional, and national health career programs; investigate the possibilities of health careers, for older as well as young people; and develop a broad-scale factfinding program on such health-manpower problems as: adequacy of educational facilities and programs for potential health workers; availability of scholarships and loan funds; aptitude testing; salary ranges in health occupations; and ways of utilizing highly trained people most effectively. The commission will also develop a program of public information and interpretation on the need for adequate staffing of services.

### Nutrition

Nutrition in pregnancy was the subject of a symposium sponsored by the Council on Foods and Nutrition of the American Medical Association at the University of Missouri Medical Center, Columbia, on October 11. The symposium was sponsored jointly by the university's school of medicine, its adult education and extension service, and the Boone County Medical Society. Several professions were represented among the speakers and panel participants and in the audience, notably physicians and medical students, nurses, biochemists, dietitians, and nutritionists.

The formal papers presented either findings from original research or generalizations based on a review of investigations and practice. Considerable emphasis was placed on the desirability of maintaining good nutritional status in girls throughout the growing period so that they may be ready for the added demands of pregnancy and lactation. It was stressed that many young wives of today have to meet these nutritional demands before they have completed their own growth. There was agreement on the need for additional studies of nutrition in pregnancy and lactation and the desirabil-

ity of adopting uniform procedures for studies undertaken in many parts of the country, especially in areas of high maternal and perinatal mortality.

### Vital Statistics

According to information from the National Office of Vital Statistics, U. S. Department of Health, Education, and Welfare:

In 1955 in the United States 146,504 infants died before, during, or soon after birth. These deaths, called perinatal deaths, included deaths of live-born infants less than 28 days of age and fetal deaths in pregnancies of 20 or more weeks. The perinatal death rate was 35.6 per 1,000 births (live and still), about the same as the 1954 rate. Among nonwhite infants the rate was 54.1 per 1,000, also about the same as in the previous year.

Among the States the perinatal death rate was lowest in Idaho, Iowa, and Utah—about 28 or 29 per 1,000—and highest, 50.1, in Mississippi. In all the rest of the States the rate was between 30 and 40 percent, except for Alabama, Virginia, Louisiana, South Carolina, Colorado, Georgia, and the District of Columbia. In Puerto Rico and the Virgin Islands the rates were above 60.

In 1955 the average life expectancy of newborn babies was 69.5 years. For those born of white mothers it was 73.6 years for girls and 67.3 for boys; for those born of nonwhite mothers it was 65.9 for girls and 61.2 for boys.

Since the period 1900-02 the average duration of life has increased by 19.1 years for white males, 22.5 for white females, 28.7 for nonwhite males, and 30.9 for nonwhite females.

### Juvenile Delinquency

Provisional findings by the Children's Bureau indicate that in 1956 juvenile-court delinquency cases increased in the United States by about 20 percent over the number handled by the courts in 1955. The child population of juvenile-court age (generally 10 through 17) increased only 3 percent for the country. The 1955-1956 increase was more than twice as great as that for 1954-1955, which was 9 percent.

On the basis of the juvenile-court statistics, the Bureau estimates that roughly 2 percent of the 20.6 million children of juvenile-court age in the United States were referred to the courts in delinquency cases in 1956. Many more children than come to the

attention of juvenile courts for delinquency—perhaps two to three times as many—are dealt with by the police for misbehavior without referral to court.

New York City recently opened a new facility for temporary detention of boys remanded by the courts. The eight-story building, accommodating 315 boys in single rooms, has seven wings and contains a reception center for incoming boys, medical-service areas, examination rooms, nurses' and administration offices, 3 workshops, 16 classrooms, recreation rooms, a library, and a central kitchen and dining rooms. The facility, called Youth House for Boys, replaces the Youth House opened 13 years ago as a part of a program of nonpunitive detention of delinquent boys which provides diagnostic reports to the courts. The program is financed by the city, but a private interfaith board appointed by the mayor administers the funds and sets policy.

### Adoptions

Principles regarding the role of a physician in adoption were discussed by 17 physicians from various parts of the country at a 2-day meeting convened by the Children's Bureau late in November.

Included in the group were specialists in obstetrics, pediatrics, psychiatry, and internal medicine, as well as doctors in general practice, public health, and hospital administration.

The time and circumstances around which a child is placed for adoption were stressed as of primary importance and there was general agreement that although the adoption process involves the rights of the natural parents and adoptive parents, the rights of the child are paramount.

The group arrived at the following principles:

The physician has direct responsibilities to the natural parent, the child, and the adoptive couple. He is responsible for arranging adequate obstetrical care for the expectant mother, a diagnostic appraisal and treatment of the child, and adequate fertility assessment and medical evaluation of the prospective adoptive couple. He has direct responsibility for referring unmarried mothers and prospective adoptive couples to authorized social agencies.

A physician also has indirect responsibilities in adoption. He serves as a

consultant for social agencies. He helps to develop hospital policies providing medical care and social services for the mother and child and prohibiting independent placements. He carries on research leading to improvement of adoption practices, such as studies in growth and development, genetics, or fertility. He helps to arouse community support for improvement of adoption services and to develop appropriate legislation in regard to adoption practices.

As an educator, the physician fosters understanding of the emotional reactions, motivations, and mental-health implications involved in adoption as he works with professional medical schools, national State and local medical societies, nursing groups, hospital administrators, and public health and welfare administrators. He participates in community-education projects involving councils of social agencies, clergymen, judges, bar associations, legislators, and school administrators.

The Children's Bureau is planning to publish a statement on the role of the physician in adoption as seen in this conference.

### Human Relations

As a result of seven regional conferences on "human-relations education," sponsored by the Anti-Defamation League of B'nai B'rith, the League recently formulated a number of recommendations addressed to State departments of education, aimed at bringing about healthier interpersonal relations in public schools. The conferences, which included teachers, school administrators, representatives of agencies fostering improved intergroup relations, and others with special skills, were held in New York, New Jersey, Illinois, California, Pennsylvania, Oklahoma, and Massachusetts.

The League urges State departments of education to give moral support to school workers who are trying to develop significant programs for improved human relations and suggests that the departments, working with concerned agencies, set up procedures for exchanging materials and experiences in this regard.

As a step toward emphasizing good human relations in the classroom, the League recommends examination of the purpose, structure, organization, and curriculum of the public school.

Teacher-training institutions, the

League maintains, should emphasize human relations in their programs so as to help students become better qualified to teach.

The strains on human relations presented by community changes should be recognized by State departments of education, the League notes, urging these departments to make help available to communities undergoing changes and to work with local people to relieve tensions.

A report on the psychological aspects of desegregation formulated by the committee on social issues of the Group for the Advancement of Psychiatry is especially addressed to educators, counselors, social workers, psychologists, and school administrators "in the hope that better understanding will facilitate use of our intellectual and social skills" in solving the problems of adjustment of both races. After identifying the psychological damage to individuals, the community and the country arising from segregation, the report discusses the psychodynamics of prejudice, the stages of attitude change, the effect of group processes on attitudes, and the role of authority and leadership in achieving change.

Recognizing that in a transitional period many children may react to the impact of newness and stress with behavior problems, the report points out that adults, in order to be able to help, must be aware not only of the defense mechanisms at work within the children but also of those within themselves. It also warns against confusing problems arising from other sources, such as lack of proper social and recreational services, with those arising from desegregation. ("Psychiatric Aspects of School Desegregation, Report No. 37." Group for the Advancement of Psychiatry, 1790 Broadway, New York 19. Price \$1; less in quantity.)

### Radiation

A committee of the World Health Organization recently drew up a plan for training public-health workers of all kinds to protect the public against nuclear radiation. Under the plan courses ranging in length from one day to several weeks are recommended as minimum preparation for meeting their responsibility for such protection. Courses are recommended for such per-

sonnel as hospital administrators, industrial-hygiene workers, sanitary and hydraulic engineers, veterinary health officers, mental-health workers, and public-health nurses, as well as for persons studying for public-health careers.

Fundamentally, the committee stated, the approach must be one of prevention through limitation or elimination of exposure, since at the present time there is little or no chance of alleviating the effects of radiation injury.

The committee pointed to the principle that public-health authorities have responsibility for protection of the public from the effects of ionizing radiation and that this responsibility begins with the selection of the site of the reactor and continues through all steps in the use of radioactivity.

At their annual meeting with the Surgeon General of the Public Health Service and the Chief of the Children's Bureau in Washington late in November, the State and Territorial Health Officers recommended that the Public Health Service develop data on safety in radiological installations and techniques in connection with Federal-State hospital construction and State licensing programs. The Association of State and Territorial Health Officers, meeting at the same time, recommended the formation of a committee to review facts and expert opinions on use of ionizing radiations and to provide advice on this subject for medical and other groups.

The Public Health Service, in a statement issued by the Surgeon General in mid-November has recommended that mass X-ray surveys for tuberculosis be conducted on a selective rather than a community-wide basis. Recommending that such surveys be continued for high-risk groups, such as persons confined to hospitals or institutions, low-income families, migrant workers, and persons known to have been exposed to radiation, the Service suggests that otherwise community case-finding programs limit the use of chest X-rays to persons reacting positively to tuberculin skin testing. The recommendations were based on the advice of a committee of medical and public health experts called together to consider recent changes in the nature of the tuberculosis problem in this country, the impact of these

changes on X-ray screening programs, and the problem of low-level radiation exposure from X-rays.

### Womanpower

"Work in the lives of married women" was the theme of a conference sponsored by the National Manpower Council and held at Columbia University's Arden House in late October. "Work," in this case, means paid employment outside the home. The 90 members of the conference were drawn from a number of fields and professions: business, industry, education, labor, religion, social welfare, social science, psychiatry, publications, government.

Using as a springboard the Manpower Council's recent report, "Womanpower," and drawing also on a number of working papers written by conference members, the group spent 4½ days discussing the implications of the widespread and growing employment of married women—a development referred to as a "revolution."

According to "Womanpower," 3 out of every 10 married women are now working. Nearly 2 out of every 5 mothers whose children are of school age are in the labor force, and about 16 percent of those whose children are under 6. A considerable proportion of the working mothers of young children have lost their husbands through death, desertion, divorce, or some other cause.

Three points were stressed repeatedly during the discussions: (1) women are marrying younger and having children younger, so that by the time the last child is out of the home the mother still has many years of active life ahead of her; (2) many women today look forward to a life in which phases of gainful employment alternate with a period of childbearing and homemaking; (3) more women today have more choice than women used to have of whether or not they will work. It was also made clear, however, that many women work because they have no choice.

Many participants expressed the belief that results of maternal employment can be favorable for the family, providing the children have adequate supervision, and the mother is able to maintain a warm, close, consistent relationship with them. To aid in this they recommended that communities

provide adequate daytime services for children.

The members saw no causal connection between maternal employment and juvenile delinquency. However, they pointed to the need for tested information about the effects of maternal employment on individual children and on the family.

### Facts and Figures

Although the number of active cases of tuberculosis has decreased almost 30 percent since 1952, about 250,000 persons in the United States are estimated to have the disease in its active form, the U. S. Public Health Service and the National Tuberculosis Association reported recently. In addition some 550,000 persons are estimated to have the disease in an inactive form. These estimates are compiled on the basis of a nationwide study carried on jointly by the two organizations. Judging from the number of previously undiscovered cases found in X-ray surveys, the PHS and the Association estimate that almost 40 percent of the active cases are unknown to medical and health authorities and that these persons are not receiving any type of care.

Under State and Federal programs in 1956 about 225,000 women received maternity medical services at public-health clinics, and 430,000 received maternity nursing services. About 517,000 infants and 617,000 preschool children (ages 1-4) were brought to well-child clinics or conferences. Nursing service was given to 1,493,000 infants and preschool children, and dental treatments to 354,000 infants and preschool children. More than 11 million children were immunized against poliomyelitis at public-health clinics; over 1,400,000 were immunized against diphtheria and 1,360,000 against smallpox. In addition to the above, more than 5½ million booster shots and revaccinations of all types were given.

Approximately 296,000 crippled children were treated by doctors in 1956; about 52,000 received 1,373,000 days' hospital care; some 3,800 received 340,000 days' care in convalescent homes. About half the patients had orthopedic handicaps. Among other conditions treated were: rheumatic fever, epilepsy, defective hearing or sight, and cerebral palsy.

# IN THE JOURNALS

## *Trainable Retarded Children*

Only for the past several years have even a few cities and States been accepting severely retarded children in their school systems, though the educable have been accepted for half a century, reports I. Ignacy Goldberg in the December 1957 issue of *Exceptional Children*. ("Some Aspects of the Current Status of Education and Training in the United States for Trainable Mentally Retarded Children.")

The author, who is associate professor of education at Teachers College, Columbia University, and assistant director of its mental-retardation project, presents: a summary of the characteristics of 1,200 trainable children in day and residential schools; figures on the estimated prevalence of severely retarded trainable children, by State, and the numbers in public and private day classes and residential schools; information on State legislative and administrative provisions concerning the education of trainable children; and a formulation of the personal, social, and vocational goals of current educational programs.

The information is based on a review of the literature and on replies from two questionnaires, one sent to selected teachers of retarded children and the other to all State directors of special education in the United States, to superintendents of schools in all cities with 50,000 population or over, and to all units of the National Association for Retarded Children.

## *Regulatory Standards*

Whatever methods are used by health and welfare departments in developing regulatory standards for operating day-care centers and other facilities for care of children or adults, the standards should represent a clearly enforceable minimum which the community is willing to accept, according to Gertrude Binder and Norris E. Class, writing in *Social Casework* for November 1957. ("Regulatory Standards for Welfare Services.")

The standards need to be acceptable also to the group of persons whose work is subject to regulation, say the authors. They further recommend that the standards be: flexible enough to allow the regulating agency to apply them equally to the various facilities without bias or caprice; flexible enough and sufficiently free of unnecessary detail to allow for individual preferences, yet not too brief; and clearly enough written to help a person who wishes to engage in the regulated activity to know what he must do.

## *Working Mothers*

What it means to a teen-age girl to have her mother go out to work was the subject of a teen-agers' meeting described in the December 1957 *YWCA Magazine*. ("Y-Teen Summer Conference.") Heading the discussion was a panel consisting of a teen-age girl whose mother was employed; an employed mother, who had four children; an employer, who was also a father; a minister; and a woman high-school teacher. About 150 teen-age girls, attending a Y-teen conference, made up the participating audience. About half the girls had working mothers.

Panel members and audience agreed that the mother's physical presence in the home does not necessarily provide good family life for teen-agers, as distinguished from younger children. Some of the girls felt that independence and a sense of responsibility sometimes develop sooner in teen-agers when their mother goes out to work. The employer noted that increasing flexibility of store schedules now permits many mothers to work during school hours only. A summary emphasized that no one pattern is best for all.

Sheldon and Eleanor Glueck, writing in *Mental Hygiene* for July 1957, reexamine the data that they published in their book, "Unraveling Juvenile Delinquency," to find out evidence concerning whether, among the 1,000 boys they studied, the mother's employment had a harmful effect on the child.

("Working Mothers and Delinquency.") Comparing 500 delinquents with an equal number of nondelinquents, the authors found that a similar proportion of mothers of both delinquents and nondelinquents were regularly employed, but that a higher proportion of delinquents had mothers who worked irregularly.

## *Cutting Waiting Time*

Reporting in *Child Welfare* for November 1957 on trends in adoptive placement in a statewide voluntary nonsectarian agency, the Washington Children's Home Society, Seattle, Elizabeth T. Bannister, the agency's assistant State director, presents figures showing that between 1951 and 1956 the agency's waiting time for families that apply for a child to adopt was cut by more than half. ("Analyzing a Statewide Adoption Agency's Statistics.") During the same period the median age of the infants placed dropped from over 4 months to less than 3 months. The author attributes these changes to changes in the agency's placement policies and in its policy in handling new applicants. These include a self-screening process through orientation meetings for couples inquiring about adoption, and monthly reviews of all newly filed applications followed by notification of each applying couple about whether or not the home study will be continued.

The author also quotes figures from the State public welfare agency showing that between 1950 and 1956 the percentage of independent adoptions by persons unrelated to the child decreased from more than half to less than one-fifth.

## *Programs to Fit the Boys*

A delinquency-prevention program designed for excitable boys might psychologically harm those of an inhibited type, and vice versa, says a clinical psychologist and a sociologist, writing in the *Journal of Criminal Law, Criminology, and Police Science* for July-August 1957. ("Personalities of Pre-delinquent Boys," by Starke R. Hathaway and Elio D. Monchesi.)

After studying 1,000 boys over a 5-year period, some of whom became delinquent, the authors note some of the relationships between personalities and delinquency. The variations in personality, they find, point to a need for diversified community programs.

# READERS' EXCHANGE

## STUDT: *Indigenous organizations*

Because new developments in delinquency prevention are rare, the recent growth of interest in seeking out and working with hostile and delinquent groups of male adolescents is of more than passing interest. Elliot Studt is to be complimented for her able analysis of the elements of group life useful in understanding the dynamics of the street-corner gang. (See "The Nature of Hard-to-Reach Groups," *CHILDREN*, November-December 1957.) Workers in this newest of vineyards thirsting for "how-to-do-it" directives will have to wait until the foundations are built through such analyses.

The dimensions of group life discussed by Dr. Studt for the most part seem to correspond to realities widely recognized by those who have worked with delinquent groups. The two likely to be the least amenable to manipulation and, therefore, most neglected in currently organized programs of street-gang work are the group's perception of the community and the community's perception of the group. Such neglect can have only unfortunate consequences since virtually all of the members of the street groups need ultimately to find their way to a stable and orderly life within the very communities which, as adolescents, they attack.

Difficulty in using indigenous adult groups and institutions constructively in work with street gangs stems from the fact that the acquisition of knowledge about such resources and appropriate relationships with those who control them is in itself a task of some magnitude. The training and orientation of the groupworker define the problem group and the worker's relationship to the group as having central importance. Other concerns tend to be treated as peripheral.

Essential in the development of work with street gangs is supplementary training of the group-worker to enable him to cultivate and use the native institutional resources of the local

community. In addition, two other patterns may be suggested. Local social agencies may employ part-time non-professional persons as street workers who, being residents of the community in which they work, have access to the institutional forces needed. Or professional group workers may be employed by youth-welfare agencies organized and led by local residents.

Solomon Kobrin  
*Sociologist, Illinois Institute for  
Juvenile Research, Chicago*

## DOUVAN: *Trouble with identity*

In reporting on the Michigan studies of adolescents, Elizabeth Douvan concludes that the concepts of adolescent independence and conflict about identity and role apply much more to boys than to girls. (See "Independence and Identity in Adolescence," by Elizabeth Douvan, *CHILDREN*, September-October 1957.)

It appears to this reader that Dr. Douvan is on more solid ground in the conclusions pertaining to independence than in those that concern identity. We have long observed that adolescent boys as compared with girls conform less to study requirements, act out more at school and home, drop out of school at a greater rate, create more hostile fads and, in general, take more vigorous action in wrenching loose strong ties to family and authority. Dr. Douvan's article affirms these observations.

The question of identity is more complex and cannot be probed adequately with the technique and the kinds of questions used in the Boy Scout and Girl Scout Studies. The studies present very limited data for concluding that "the question of identity is postponed for them" (girls).

The problem of identity for girls not only exists in intensity, but is more difficult to resolve than in the case of boys. True, the girl has to postpone her chief feminine role, marriage. Nevertheless, she is very concerned about whether she will be loved for

herself; whether her father will support her feminine development; whether her mother will withdraw support as she shows signs of being a sexual person with concerns about popularity, looks, dating manners, and styles. Though on the surface all looks calm, these are deep concerns about identity.

The University of Michigan Study interviewers could not penetrate into these matters because of the structure of the questioning and because girls do not verbalize readily to a stranger, or to themselves, on such critical subjects. Better evidence of how they feel would be revealed by studies of fatigue and illness, physical complaints to school nurses, autobiographical material gathered over a period of time, and reports of parents regarding temperamental behavior and sensitivity in their daughters.

Moreover, while boys seem to have a more immediately attainable goal in industrial productivity, girls also are concerned about this goal. High-school girls in lower-middle and lower-class families who know that they will not continue much longer in formal schooling show very real concern about a known future involving both marriage and work. My studies show that in the tenth grade girls are quite preoccupied about the industrial role they will develop, with the familiar anxiety attending the problem of conflicting choices.

If anything, the problem of acquiring a gratifying identity is more of an issue for postpubescent girls than boys because of the multiple roles they must learn for the complex style of femininity in our culture. Possibly this is why they give more to their school studies than do boys. Doing well in school may afford an acceptable self-image and relief from other decisions.

With respect to identity, both boys and girls in junior and senior high school are involved and concerned. Each presents a distinctive problem. In their search the boys seem to act out a lot of the problem; the girls worry it out internally, turn some of it into somatic complaints and—a definite clue to concern about identity—become more dependent on mothers and teachers.

Donald McNassor  
*Professor of Education, Claremont  
Graduate School, Claremont, Calif.*